**View Point Health
Autism Services Referral**





###

###  Date of Referral:

### Individual’s Name:       DOB:       Age:     SSN:

Is individual currently receiving care from VPH? Y [ ]  N [ ]  (If Y, please include CID#     )

Primary Language (Hispanic or other)       Is Individual aware of your referral? Y [ ]  N [ ]

Individual’s Home Address:       City:       County:       Zip:

Main Phone #:       Email (if applicable)       Is Individual currently homeless? Y [ ]  N [ ]

Is Individual currently on probation? Y [ ]  N [ ]  (If Y, please provide PO contact information with referral)

Does Individual have a legal guardian? Y [ ]  N [ ]  (If Y, please include legal guardian information with referral)

Emergency Contact Name       Emergency Contact Phone #       May VPH contact Emergency Contact? Y [ ]  N [ ]

**What service are you referring to? Please select all that apply**

|  |  |
| --- | --- |
| [ ]  **Diagnosis/Assessment**[ ]  **ABA Therapy**[ ]  **Occupational Therapy** | [ ]  **Speech Therapy**[ ] **Feeding and Swallowing Therapy**[ ] **Family Education and Support** |

Name of Person Referring:       Email:       Phone #:

**Any previous/current mental health diagnosis? Please select from below:**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ] Mood Disorder[ ] ADHD[ ] Autism Spectrum |  [ ] Depression [ ] Anxiety  [ ] Bipolar  |  [ ] Phobia [ ] Schizophrenia [ ] IDD | [ ] Other:      When was the most recent diagnosis?       |

Substance Abuse Diagnosis (if applicable)       Is Individual’s SA diagnosis for at least 6 months? Y [ ]  N [ ]

Medical/Physical Challenges or Diagnoses (if applicable)       Current Medications (if applicable):

**Please select all applicable challenges below for the Individual referred:**

[ ]  Hygiene [ ]  Nutritional [ ]  Maintaining personal affairs [ ]  Housing [ ]  Ability to avoid danger/hazards

[ ]  Daily living skills [ ]  Sustainable employment [ ]  Safe living situation [ ]  Other

**Please select any of the following services the Individual has received in the past:**

|  |  |
| --- | --- |
| [ ] Outpatient mental health services? If yes where       [ ]  IDD services? If yes where        | [ ] Psychiatric Hospital? If yes how many       [ ] Homelessness? If yes # of episodes       [ ] Jail? If yes # of incarcerations        |

**Please select any applicable benefits for the Individual**

|  |  |  |
| --- | --- | --- |
|  [ ] Medicaid (#     ) [ ] Medicare (#     ) |  [ ] SSI (Monthly amount:      ) [ ] Private Insurance |  [ ] Payee (Name of Payee:      ) [ ]  Other:       |

Please provide a brief description of presenting problems and current behaviors

**FINAL STEP - Please email referral form and all supporting documents to autism@vphealth.org**

Thank you for the referral. If you do not hear from us within 48 hours, please contact Pej Mahdavi at (pej.mahdavi@vphealth.org).