**View Point Health  
Community 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 #:       Is Individual currently homeless? Y  N

**\*\*If residing at State Hospital and/or homeless, please list individual’s county of residence**

Does Individual have a legal guardian? Y  N  (If Y, please include guardianship paperwork with referral)

Legal Guardian’s Name:      \_\_\_\_\_\_\_\_\_\_ Legal Guardian’s Main Phone #:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where are you referring from? Please select one**

|  |  |  |
| --- | --- | --- |
| *If from IP setting, does referral have a d/c date scheduled:*  Y  N  Date:  GA State Hospital  Private Acute Hospital  Crisis Stabilization Unit | DBHDD  Court  Probation Office  County Jail  State Prison | Public Defender’s Office  Another Agency Referral  Re-entry (County      )  VPH OP, Location:  Other: |

Name of Person Referring:       Email:       Phone #:

**\*Must have a verified diagnosis for severe and persistent mental illness. Please select:**

|  |  |  |  |
| --- | --- | --- | --- |
| Schizophrenia  Schizoaffective/  Type: | Depression  Bipolar | Anxiety  Other: | For anyone 16-30 yo, is psychosis onset within past 24 months? Y  N |

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

Medical/Physical Challenges/Diagnoses (if applicable)       Current Medications (if applicable, attach list):

**Please select all applicable challenges/needs below (2+ required):**

Hygiene  Nutritional  Maintaining personal affairs  Medical  Legal  Ability to avoid danger/hazards

Daily living skills  Sustainable employment  Housing/ Safe living situation  Other:

**Past 12 months- Please select any of the following services the Individual has received:**

|  |
| --- |
| Psychiatric Hospital (# of admissions      ) # in the past 180 days  Crisis Stabilization Unit (# of admissions      ) # in the past 180 days  Jail (# of incarcerations      ) # in the past 180 days  List facilities (jails/hospitals) and dates:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Past 6 months- Please select any of the following services the Individual has received:**

|  |
| --- |
| Community-Based Services-Please describe which service (eg PSR, ICM, CM):  In-clinic crisis stabilization. Location and dates:  Forensic: Competency Restoration. Location and dates:  Other: |

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

|  |  |  |
| --- | --- | --- |
| Medicaid (#     )  Medicare (#     ) | SSI (Monthly amount:      )  \*Private Insurance/specify:      ) | Uninsured/SCS  Other: |

**\*\*\*FINAL STEP - Please email referral form and all supporting documents to** [**referrals@vphealth.org**](mailto:referrals@vphealth.org)**\*\*\*\***

Thank you for the referral. We’ll contact you immediately if we need further information or need to discuss next steps.

If you have not heard from us within 48 hours, please contact Chad Jones(Chad.Jones@vphealth.org).