**View Point Health
Outpatient Services Referral Form**





### **Date of Referral:**

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

Is individual currently receiving care from VPH? Y [ ]  N [ ]  Primary Language

Is Individual aware of your referral? Y [ ]  N [ ]

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

Main Phone #:       Is Individual currently homeless? Y [ ]  N [ ]

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**

|  |  |  |
| --- | --- | --- |
| [ ] 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      )  [ ] Family/friend  Other       |

Name of Person Referring:       Email:       Phone #:

Reason you are referring:

Substance Use Disorder Diagnosis (if applicable)

Current Medications (if applicable, attach list):

**Past 12 months- if know, 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:      ) [ ] \*Individual has Private/commercial Insurance/specify:      ) |  [ ]  No insurance coverage [ ]  Other:       |

\*\*\*Please complete and submit to OutpatientServices@vphealth.org \*\*\*

Thank you for the referral. We’ll contact you within 24 hours if we need further information.

If you have not heard back within 48 hours, please contact Julie.Solinski@vphealth.org