**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](mailto: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](mailto:Julie.Solinski@vphealth.org)