



View Point Health Referral STRIVE CLUBHOUSE

1775 Access Road, Covington, GA 30014 | 678-209-2446

Please email completed referral form and any supporting documentation to strive@vphealth.org

Contact Information:

Date of Referral: _____

Youth's Name: _____ MI: _____ Last Name: _____ DOB: _____ SSN: _____ (N/A) Age: _____ Gender: _____
 Youth's Primary Language _____ Insurance Carrier Name: _____ Medicaid # _____ No Insurance (Yes or No) _____
 Parent/Guardian's Full Name: _____ Relationship to youth: _____ Guardian's Primary Language _____
 Home/Placement Address: _____ City: _____ Zip: _____ County: _____ Living Situation: with family _____ not family _____
 Guardian's Phone #: _____ Youth's Phone #: _____ Guardian's Email Address: _____

Please note STRIVE's Clubhouse Services and Eligibility Criteria:

SERVICES	ELIGIBILITY CRITERIA
<ul style="list-style-type: none"> Assessment & Evaluation Individual 1-1 Counseling Group Skills Training Group Psychotherapy Counseling Family Skills Group Case Management Academic Support Meals Provided Field Trips Transportation (10 Mile Radius) 	<ul style="list-style-type: none"> K-12 Grades Mental Health Diagnosis Medicaid/CMO accepted Not accepted: Substance Use in the last 6 months ASD or other intellectual diagnosis No hospitalization in the last 6 months No suicidal or homicidal thoughts in the last 6 months No eating disorder No Private Insurance Other:

Presenting Problem/Diagnosis: Mental Health Substance Use Prevention

ALL the information below MUST BE COMPLETED:
 Describe challenges/behaviors the youth is having: (i.e. at home, in school and/or community):

Is youth receiving care at View Point Health? (Yes or No) _____

Please select all applicable emergent and crisis needs:

Self-harm Suicidal thoughts Suicide attempts Terroristic Threats Homicidal thoughts or behaviors
 Runaway Substance Use Imminent Risk of Out-of-Home Placement Eating Disorder: _____
 Sexual abuse or behaviors: _____ Recent hospitalization: _____ IEP/504: _____ Other: _____

Referring Party Information:

Name: _____ Email: _____ Phone: _____

<input type="checkbox"/> Internal <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Residential Facility (PRTF) <input type="checkbox"/> DJJ In Community <input type="checkbox"/> DJJ Secure Facility	<input type="checkbox"/> DBHDD Core Provider <input type="checkbox"/> Private MH Provider or Pediatrician <input type="checkbox"/> Juvenile Court <input type="checkbox"/> DFCS <input type="checkbox"/> Children & Family Coalition <input type="checkbox"/> Community Organization <input type="checkbox"/> Friend	<input type="checkbox"/> System of Care (LIPT/CHINS/CSEC) <input type="checkbox"/> School System <input type="checkbox"/> Crisis Stabilization Unit (CSU) <input type="checkbox"/> Family Support Organization <input type="checkbox"/> Faith-Based Organization <input type="checkbox"/> Other: _____ <input type="checkbox"/> View Point Health: ECR# _____
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Education:

Name of School Attending: _____ County: _____ Grade: _____ Services: _____ EBD/Psychoeducation _____
 Alternative School _____ Currently: Suspended: _____ Expelled: _____
 Medical/Physical Challenges or Diagnoses (if applicable): _____ Current Medications (if applicable): _____

Please return completed form and any supporting documentation to strive@vphealth.org

We will review your referral and contact you within three business days to discuss. We look forward to working with you!