Virginia Family Services
Intensive In-Home
Referral Form
Phone: (804) 313-6767   Fax: (888) 214-4776

Date of Referral: ____________________________

Client Name: ____
DOB: ______________________________ Age: __________ Gender: ______
SSN: _______________________________ Race: ________________________________
Medicaid#: _______________________ HMO Name: ____
Parent/Guardian: ____
Phone: ________________________ Email: ______________________________
Address: ____

Presenting Problems/Risk Conditions:

List present/past services being received: (in home counseling, group home, day treatment, outpatient therapy, case management)

How did you hear about VFS? ____

If Referral given by someone other than client or parent/guardian:

Referral Source Name: ____

Agency: ____

Phone: _____________________________________ E-mail: ______________________________________

VFS employee completing referral: ____

Client meets at least **TWO** of the following criteria on a continuing or intermittent basis:

☐ Has difficulty in establishing or maintaining normal personal relationships to such a degree that he or she is at risk of hospitalization or out-of-home placement because of conflicts with family or community.

☐ Exhibits such inappropriate behavior that repeated interventions by the mental health, social service, or judicial system is necessary.

☐ Exhibits difficulty in cognitive ability such that he or she is unable to recognize personal danger or recognize significantly inappropriate social behavior.

Name of medication: ____
Prescribing Physician: ____