Virginia Family Services
Mental Health Skills-Building Services
Referral Form
Phone: (804) 313-6767 Fax: (888) 214-4776

Date of Referral: _____

Client Name: _____
DOB: _____ Age: _____ Gender: _____
SSN: _____ Race: _____
Medicaid#: _____ HMO Name: _____
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:

Referral Source Name: _____

Agency: _____

Phone: _____ E-mail: _____

VFS employee completing referral: _____

Client must meet **ALL** of the following criteria:

☐ Individual has a history of psychiatric hospitalization, Intensive Community Treatment, crisis stabilizations services, PACT (Program of Assertive Community Treatment), Residential Treatment or TDO.

☐ Individual needs assistance with activities of daily living related to symptom management, compliance with psychiatric and medication treatment plans, development of social skills and support systems, person hygiene, food preparation, or money management.

☐ Individual has been diagnosed with one of the following diagnoses: Bipolar I or II, Major Depressive Disorder, Schizophrenia, or other psychotic disorder or another Axis I disorder that is severe and debilitating and documented by a physician.

☐Individual has been on a psychotropic medication in the past 12 months.
Name of medication: _____
Prescribing Physician: _____