THE VASHTI CENTER REFERRAL FORM

Attn: Intake Coordinator Fax: 229-584-1941 Email: vashtireferral@vashti.org

Date_____

Referral Source:

- ☐ Self
- ☐ Family
- ☐ Physician
- ☐ School
- ☐ DFCS
- ☐ State Hospital
- ☐ Law Enforcement
- ☐ Clergy
- ☐ Criminal Court
- ☐ Juvenile Justice
- ☐ Access/Crisis Line
- ☐ Other: _____

Special Population

- ☐ Hearing Impaired
- ☐ Vision Impaired
- ☐ Pregnant
- ☐ SSI/Disabled

Referring agency name: _____

Contact Person:_____Contact phone number: (___)_____

Agency Address: _____

_____

Consumer Information:

Consumer Name: _____

Age_____ Sex: M___F___DOB: _____ Race:_____Social Security Number:_____

Residential Address: _____

_____

Guardian name: _____ Phone: (___)_____

Attached Information:

Please note that referrals must include previous inpatient or outpatient mental health records *prior* to an assessment appointment being scheduled with The Vashti Center. **Please mark the following documents that are attached with the referral:**

- ☐ Psychiatric or psychological evaluation
- ☐ Behavioral health assessment from previous mental health provider
- ☐ Most recent psychiatric *or* pediatric progress note
- ☐ Discharge summary
- ☐ Other: _____

Payment Source: (Please note that we MUST have this number)

Medicaid #: _____

Reason for referral:

_____

_____

Is this referral for Ventures on Broad Clubhouse (Thomas County Only): ☐

Office use only

Form # 0032(Revised 7.15.2016)

Staff Receiving Referral: _____

Date: _____

Assessor: _____

Assessment date: _____