TURNING POINT INTERVENTIONS, LLC
4545 Riverside Drive, Suite C, Danville, VA 24541 | Phone (434) 228-7526 | Text (434) 630-8494 | Fax (888) 767-7937

"Helping Hands That Heal"

REFERRAL FORM

Fax completed form to (888) 767-7937 • Call (434) 228-7526 • Text (434) 630-8494

This form is not for emergencies. If the individual is in immediate danger, call **911**. For a mental health or substance use crisis, call, text, or chat **988**, or bring the individual to the TPI 23-Hour Crisis Center (open 24/7) at 4545 Riverside Drive, Suite C, Danville.

TPI contacts every new referral within 1 to 3 business days. Please complete all sections that apply; incomplete referrals may delay contact.

1. Service(s) Requested (check all that apply)

Crisis Services

- ☐ 23-Hour Crisis Stabilization (center-based, open 24/7)
- ☐ Community Stabilization (available until DMAS ends coverage of this service)

Community-Based Services

- ☐ Mental Health Skill-Building (MHSS) – **Adults** (age 18+)
- ☐ Intensive In-Home (IIH) – **Youth** (under age 21) and family

Outpatient Services

- ☐ Outpatient Therapy (individual, family, or group)
- ☐ Psychiatric Evaluation and Medication Management
- ☐ Comprehensive Assessment only

Date of Referral: _____ **Requested Start Date:** _____

☐ Routine ☐ Urgent (needs contact within 24 hours) ☐ Transition from hospital / crisis service – Discharge date: _____

2. Individual Information

Legal Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Pronouns:** _____

Street Address: _____

City: _____ **State:** _____ **ZIP:** _____ **County/City of residence:** _____

Phone: _____ **Email:** _____

☐ OK to leave a voicemail ☐ OK to text this number ☐ Interpreter needed – Language: _____

Race/ethnicity (optional, for reporting): _____ Veteran: ☐ Yes ☐ No

Parent / Guardian / Authorized Representative (required for individuals under 18)

Name: _____ **Relationship:** _____

Phone: _____ Lives in same household as youth? ☐ Yes ☐ No

☐ Caregiver is willing to participate in services (required for Intensive In-Home)

3. Insurance

☐ Aetna Better Health of VA ☐ Anthem HealthKeepers Plus ☐ Humana Healthy Horizons
☐ Sentara Health Plans ☐ UnitedHealthcare Community Plan ☐ Virginia Medicaid (Fee-for-Service)
☐ Medicare ☐ Commercial: _____ ☐ Self-Pay

Medicaid / Member ID #: _____ **Plan / Group #:** _____

4. Clinical Information

Diagnosis(es), if known: _____

Reason for referral / presenting concerns:

_____

_____

_____

Current risk (check all that apply):

☐ Thoughts of suicide (past 30 days) ☐ Thoughts of harming others (past 30 days) ☐ Self-harm (past 30 days)
☐ Psychiatric hospitalization (past 12 months) ☐ Crisis/ED visit (past 90 days) ☐ Current substance use concerns
☐ Hallucinations, delusions, or unusual thoughts ☐ Legal involvement / probation ☐ None known

For MHSS referrals (check all that apply):

☐ Prior psychiatric hospitalization, residential crisis stabilization, TDO, ICT/PACT, or psychiatric residential treatment
☐ Primary diagnosis of a psychotic disorder, major depressive disorder, bipolar I/II, or other serious mental illness
☐ Needs skills training to live independently

For IIH referrals:

☐ Youth is at risk of out-of-home placement ☐ Youth is returning home from an out-of-home placement

Current or past services (outpatient therapy, case management, crisis, inpatient, IOP/PHP, group home, school-based, etc.):

_____

_____

☐ Individual has had a prescription for an antipsychotic, mood stabilizer, or antidepressant in the past 12 months (required for MHSS)

Medication(s): _____

Prescriber: _____ **Phone:** _____

Primary Care Provider: _____ **Phone:** _____

School / Grade (youth): _____ **Employer / Program (adults):** _____

5. Referral Source

☐ Self ☐ Family ☐ Hospital / ED
☐ CSB / Emergency Services ☐ Primary Care / Physician ☐ School

☐ DSS / Court / Probation ☐ MCO Care Coordinator ☐ Other: _____

Referring Person: _____ **Agency:** _____

Phone: _____ **Fax:** _____ **Email:** _____

How did you hear about TPI? _____

☐ The individual (or guardian) knows about and agrees to this referral and to TPI contacting them.

Referral sources sending substance use disorder records must include a signed 42 CFR Part 2 consent. TPI will not share treatment information back with the referral source without the individual's written authorization, except as permitted by law.

For TPI Office Use Only

Received by: _____ **Date/Time received:** _____

First contact date: _____ Insurance verified: ☐ Yes ☐ No

Assessment scheduled: _____ **Assigned to:** _____

☐ Admitted ☐ Not admitted – referred to: _____ ☐ Unable to reach (3 attempts documented)