Vaya Health

# Geriatric and Adult Mental Health Specialty Team Referral Form

Vaya Health's (Vaya's) Geriatric and Adult Mental Health Specialty Team (Geriatric Team) offers free education and support for professional staff and family caregivers in Alexander, Alleghany, Ashe, Avery, Buncombe, Burke, Caldwell, Catawba, Cherokee, Clay, Graham, Haywood, Henderson, Iredell, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Surry, Swain, Transylvania, Watauga, Wilkes, Yadkin, and Yancey counties.

The team includes registered nurses, licensed clinicians, and qualified mental health professionals. Education and support focus on caring for individuals age 60 and older who are experiencing mental health or substance use issues, dementia, or other emotional or behavioral challenges. The team also serves caregivers of younger adults with dementia. For professionals, the program offers contact hours approved by the NC Division of Health Service Regulation (DHSR).

**To refer a caregiver to the program, complete the form below. Please submit all referrals through our confidential fax number at 1-877-355-2436. We will contact you within three business days from the date the referral is received.** For more information, call 1-800-893-6246 and enter the extension for the Vaya office nearest you — Asheville at ext. 2993 or Lenoir at ext. 3346 — or contact Geriatric Team management at 1-800-893-6246, ext. 3332 or email geriatric.team@vayahealth.com.

## Referrer Information

Referral date: _____ Organization making referral: _____

Referred by: _____ Phone: _____

Was the referred party informed of referral? ☐ Yes ☐ No

Does the referred party consent to Vaya leaving a voicemail? ☐ Yes ☐ No

## Caregiver Information

Caregiver name: _____ Phone: _____

Caregiver relationship to person being referred (e.g., guardian, spouse, child): _____

Physical address: _____ County: _____

Mailing address: _____ ☐ Same as above

## Information About Individual Receiving Care

Individual name: _____ Maiden name (if applicable): _____

Is the individual already served by Vaya? ☐ Yes ☐ No

**IF YES:** Enter the individual's medical record number, if known: _____

Date of birth: _____ County: _____

Physical address: _____

Mailing address: _____ ☐ Same as above

## Reason for Referral

Include any symptoms, challenging behaviors, and indications for needed supports: