# Elements of Motivation
# Referral for Services

Thank you for considering Elements of Motivation for your Mental and Behavioral health services. The preferred method of submission is electronically through our online referral portal:

https://elementslv.com/refer-a-client

Please only use this paper version **only** if electronic submission is not an option. To submit this referral, please fill it out entirely, scan it, and email it to admin@elementslv.com

| Client Name | Primary Insurance Number | Date of Birth |
|---|---|---|
| | | |
| | | |
| | | |

Secondary Insurance for any clients listed above? _____

Where/with whom does this client live (First/Last Name)? _____
Relationship to client? _____
Client Address, please list where the client currently resides: _____
_____
Phone Number- (Caregiver's phone number for MINORS): _____

**Adult Client** Email Address:_____
**Minor Client** GUARDIAN'S Email Address(es):
Parent/Guardian #1 email: _____
Parent/Guardian #2 email:_____
Guardians are:

- ☐ Married
- ☐ Divorced/Separated/Never Married WITH Legal Custody Arrangements
- ☐ Divorced/Separated/Never Married WITHOUT Legal Custody Arrangements
- ☐ No contact/whereabouts unknown, WITH Legal Custody Arrangements
- ☐ No contact/whereabouts unknown, WITHOUT Legal Custody Arrangements
- ☐ Other: _____

*FOSTER CARE ONLY*: Birth parent(s) Name(s), Address, and Phone number (if they will be involved in treatment at any point):

_____

**Referral Information**
Referral Source Name/Relationship to Referred Client:_____
Referral Source Phone Number:_____
Referral Source Email Address:_____
Would you like a Release of Information form to be completed by this client for communication between the therapist and referral source? _____

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**Services Requested?** *Please circle:*

| | | |
|---|---|---|
| Individual therapy | Family therapy | Couple Therapy |
| Substance Abuse Counseling | Therapeutic Supervised Visitation | |
| Mental Health Assessment | PSR(Psychosocial Rehabilitation) | |
| BST(Basic Skills Training) | 157 DV Assessment | Other:_____ |

**Service Setting**

☐ *Telehealth*- Yes, telehealth is fine.

☐ *In-Office*- **MAY BE WAITLIST** No, this client must have IN-PERSON therapy in the OFFICE (Sahara/Rainbow).

☐ *In-Home*– **WAITLIST** This client must have services IN HOME. I understand there is a wait for this service and I have spoken to Lori (lori@elementslv.com) about the needs of this client/family.

☐ Unsure, please contact client for preference

**Availability**

Please be as detailed as possible with days and hours available (i.e. M-F after 4pm, Saturday 10am-12pm). We will use this to match you with a therapist who has availability!

_____

**Additional Services Information**

Is the client currently receiving Mental Health services from another agency? _____

Has the client received Mental Health services from another agency in this calendar year? _____

**Reason for Referral**

Any information you provide here will help us to assign a therapist with a skill set appropriate for the needs of this family and who we believe will be the best fit to provide the requested services. Please note any urgent needs, risk factors, safety concerns, observed/reported behaviors, or other special circumstances related to this referral:

_____

_____

_____

**Culturally-Sensitive and Competent Care**

Are there any cultural considerations we should keep in mind for this client/family (language, communication styles, beliefs, attitudes, behaviors)? Please indicate if consenting adults would prefer Spanish language consent forms. _____

**Clinician Request** Requesting a specific clinician? Great! Please write their name here and we will do our absolute best to match you with that clinician: _____