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 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 Information-

Client Name:_____
Date of Birth:_____
PRIMARY Insurance
Type/Number:_____
SECONDARY Insurance
Type/Number:_____

Are there any additional/related clients? Please list their information below:

Client Name	Insurance type/number	Date of Birth

Client/Caregiver/Consenting Adult Contact Information-

Where/with whom does this client live? Please select one:

- ☐ Self/Adult
- ☐ Birth Parent(s)/Other Family Member(s)
- ☐ Adoptive Parent(s)
- ☐ Child Haven
- ☐ Foster Parent(s)/Group Home
- ☐ Homeless/Runaway
- ☐ Other:

Client Address, please list where the client currently resides-

Address:_____
City/State:_____
Zip code:_____

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Phone Number- Where client can currently be reached (Caregiver's phone number for MINORS)
Client phone number:_____

Adult Client Email Address-
Self consenting adult email address:_____

Minor Client Email Address-
Please list the email address(es) of the client's guardian(s)
Parent/Guardian #1 email: _____
Parent/Guardian #2 email:_____

Note; IF the client you are referring is a MINOR, the parent(s) or the legal guardian(s) must sign informed consent forms. If there are two parents or two guardians, both whom are involved in the minor's life, both of them must consent to services (unless they are married or provide legal documentation showing "sole legal custody").

We will send electronic consents for this client to receive treatment.
IMPORTANT: Please add adobesign@adobesign.com to your address book to avoid missing emailed consents that must be signed before treatment begins.

List the name(s) of the Adult(s) with whom this minor lives-
Parent/Guardian #1 First Name:_____ Last Name:_____
Parent/Guardian #2 First Name:_____ Last Name:_____

Is this a parent/guardian/foster parent? Please circle one. Other?_____

Please indicate the relationship between Parent/Guardian #1 and Parent/Guardian #2, please select:

- ☐ 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? List it here:_____

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

Referral Information-

Referral Source Name:_____
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? Please select one:

☐ Yes ☐ No ☐ Not Applicable

Relationship of Referral Source to Referred Client? Please select one:

☐ DFS Caseworker
☐ Doctor's Office
☐ Community Partner (i.e. Harbor, Group Home)
☐ Self Referral
☐ Other:_____

Services Requested-

What services are you requesting for this client? Please select:

☐ 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:_____

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Service Setting-

Is this client/family a candidate for telehealth services to be provided by video?
NOTE: In-person, especially in-home services are extremely limited and may be subject to being placed on our waitlist.

- ☐ Yes, telehealth is fine.
- ☐ **MAY BE WAITLIST** No, this client must have IN-PERSON therapy in the OFFICE (Sahara/Rainbow).
- ☐ **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.
- ☐ Other:_____

Availability-

Please be as detailed as possible with days and hours available (i.e. M-F after 4pm, Saturday 10am-12pm). Weekday, daytime hours are preferred for those who are able as many therapists are completely booked after 2pm M-F. We will use this to match you with a therapist who has availability!

- ☐ Monday:_____
- ☐ Tuesday:_____
- ☐ Wednesday:_____
- ☐ Thursday:_____
- ☐ Friday:_____
- ☐ Saturday:_____
- ☐ Sunday:_____
- ☐ Unsure, please contact client for preference

Delay in submitting scheduling information will result in delayed initiation of services

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Additional Services Information-

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

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Other:_____

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

- ☐ Yes
- ☐ Unsure
- ☐ No
- ☐ Other:_____

Reason for Referral-

The assigned therapist will be in contact with you prior to contacting the caregiver, however, 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:

_____

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