

**All About You Counseling and Support Services Phone: 702-754-0807**

**8685 S. Eastern Ave. Fax: 702-754-0808**

**Las Vegas NV 89123 www.allaboutyoucounseling.org**

**REFERRAL FORM**

**Directions:** Upon completion, please submit the form by email (for fastest response) to **drtonie@allaboutyoucounseling.org** or fax to **(702) 754-0808**

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| **IN OFFICE USE ONLY****Date of Referral:       Therapist Assigned:**      **Intake Scheduled Date:**       **Intake Time:**       **Due of Date:**      **Comments:**       |

**Client Name:**  **Date of Birth:**   **Sex: Age:**

**Insurance Type:**  **Insurance Number:**

**Insured/Insured DOB:**

**Client in DFS Custody? [ ]** Yes [ ]  No **If “YES” Date Taken in Custody:**

**LEGAL GUARDIAN(S) INFORMATION**

**Legal Guardian(s) Name:**

**Relationship to Client:**

**Address:**  **Phone -**

 **Phone -**

 **Phone -**

**E-mail:**

**Note:**

**RESIDENCE INFORMATION**

**Custodian(s) Name:**

**Relationship to Client:**

**Address:**  **Phone -**

 **Phone -**

**Gate Code/Cross Streets:**

**REFERRAL INFORMATION**

Please describe the concerns that the client is currently experiencing:

**Referral Source:**

Name: Contact Number: Fax:

E-mail:

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| Have you ever been seen by a psychiatrist? [ ]  Yes [ ]  NoIf so, who and when?       | Does the client have Suicidal Ideation? [ ]  Yes [ ]  NoIf “YES”, Please Describe       |
| Have you ever been In-Patient Hospitalized due to psychiatric concern? [ ]  Yes [ ]  NoIf “YES”, Please Describe       | Is the client a Danger to Self/Others? [ ]  Yes [ ]  NoIf “YES”, Please Describe:       |
| Has the client ever participated in mental health treatment with another organization? [ ]  Yes [ ]  No* Individual/Family Therapy? [ ]  Yes [ ]  No

 If “YES”, Please Describe:       * Group Therapy? [ ]  Yes [ ]  No

 If “YES”, Please Describe:      * Substance Abuse Counseling? [ ]  Yes [ ]  No

 If “YES”, Please Describe:      * Partial Hospitalization? [ ]  Yes [ ]  No

 If “YES”, Please Describe:      * Rehab Services (PSR/BST)? [ ]  Yes [ ]  No

 If “YES”, Please Describe:       | Is there or has there been domestic violence? [ ]  Yes [ ]  NoIf “YES”, Please Describe (Who, What and When):       |

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|  **[ ]** Individual Therapy [ ]  Psychosocial Rehabilitation [ ]  Family Therapy [ ]  Basic Skills Training [ ]  Group Therapy  |

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| **Client’s Availability** |
|  **[ ]** In-Home **[ ]** In-Office   **[ ]** Monday:       **[ ]** Thursday:       [ ]  Tuesday:       **[ ]** Friday:       [ ]  Wednesday:       **[ ]** Weekend:        |
| Notes:       |