

**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**](mailto: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  No  If so, who and when? | Does the client have Suicidal Ideation?  Yes  No  If “YES”, Please Describe |
| Have you ever been In-Patient Hospitalized due to psychiatric concern?  Yes  No  If “YES”, Please Describe | Is the client a Danger to Self/Others?  Yes  No  If “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  No  If “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: |