Sandia Family Therapy
Behavioral Health Services Referral Form
Phone: (505) 913– 1473| Email: mauricio@sandiafamilytherapy.com
Address: 1202 Main St, Suite 101, Los Lunas, NM 87031

Referral Information

Date of Referral: _____

Referred By (Name/Organization): _____

Phone: _____ **Fax/Email:** _____

Relationship to Client: ☐ Self ☐ Parent/Guardian ☐ Provider ☐ Other: _____

Client Information

Client Name: _____**Date of Birth:**_____
Gender: ☐ Male ☐ Female ☐ Nonbinary ☐ Other: _____

Address: _____

City/State/ZIP: _____

Phone: _____**Email:** _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Text ☐ Other: _____

Parent/Guardian Information

(If client is a minor)

Parent/Guardian Name: _____

Phone: _____

Email: _____

Reason for Referral

Please describe the reason for referral and/or presenting concerns:

Requested Services:
☐ Individual Therapy ☐ Family Therapy

Safety/Support Needs

Is the client currently experiencing:
☐ Suicidal thoughts ☐ Self-harm ☐ Aggression/Violence ☐ Substance use concerns ☐ None reported

If yes, please provide details or risk concerns:

Insurance / Payment Information

Insurance Provider: _____

Member ID: _____

Policyholder Name: _____

☐ Self-pay ☐ Medicaid ☐ Private Insurance ☐ EAP ☐ Other: _____

Referral Submission

Please return this completed form via Email to mauricio@sandiafamilytherapy.com

Thank you for referring to **Sandia Family Therapy**. We will contact the client within **2–3 business days** of receiving this referral.

• • *Taking one step at a time* • •