New Beginnings

BEHAVIORAL HEALTH SERVICES REFERRAL FORM

Please complete the information below and fax to 702-631-0809 or e-mail larry@newbeginningslv.org

Client's last name_____ Client's first name_____
DOB_____ Gender (M/F) _____ Ethnicity_____ SS#_____
Fee-for-service Medicaid eligible ____Yes ___No Insurance ID#_____

Is the client currently in an out-of-home placement? ___Yes ___No If yes, please check below the type of placement:
____Hospitalization ___Foster Care ___Other (please explain) _____
Provide name of placement (agency, family member other) _____
Address of placement_____ Phone number_____
Anticipated discharge date from out-of-home placement_____

Parent/Guardian name_____ Relationship to client _____
Home address_____ City, State, Zip _____
Home phone #_____ Work phone#_____ Cell phone#_____

What Behavioral Health Services/Medication Management is this child **currently** receiving?

Service	Provider of Service	Service start date	How often is the service provided?	Actively participating in treatment	Provider's phone #
				___Yes ___No	
				___Yes ___No	
				___Yes ___No	
				___Yes ___No	
				___Yes ___No	

Briefly describe any pervasive behavioral needs or general concerns_____
_____
_____

What type(s) of behavioral health service(s) are you seeking from NEW BEGINNINGS?
___ SED determination or comprehensive assessment
___ Psychosocial Rehabilitation: ___Private In-home ___In-office
___ Basic Skills: ___Private In-home ___In-office
___ Anger Management
___ Parent Training
___ Intensive Psychotherapy: ___Individual ___ Group ___Family
___ Speech Therapy

Person completing this form_____ Agency (if applicable) _____
Phone _____ Fax _____ E-mail _____
Mailing address _____ City, State, Zip_____

*HAS CHILD, ADOLESCENT, OR FAMILY BASED BEHAVIORAL SERVICES BEEN DISCUSSES WITH THE POTENTIAL CLIENT(S) AND THEY ARE IN AGREEMENT TO RECEIVE THE SERVICE(S)? ___YES ___NO