REFERRAL FORM

Please complete the following and send this form, and any additional information to:

BBSreferral@mentesanalv.us or fax to 702 450-4239

ATTN: Front Desk, Office number: 702 451-7542

2255 Renaissance Dr. Suite A

Las Vegas, NV 89119

DEMOGRAPHICS

Client Name: _____ **Date of Birth/Age:** _____

Insurance Type: _____ **Policy Number:** _____

Client Address: _____ **Phone Number(s):** _____

City/State/Zip: _____ **Caretaker name:** _____

Referring Person/ Agency _____

Phone Number: _____

Email: _____

REQUESTED SERVICES (Mark all that apply)

Assessment Only (with recommendations only, no services)

- ☐ Child
- ☐ Adult

Assessment (with services – specify services desired below)

- ☐ Child
- ☐ Adult

Services Requested (assessment required; services based on medical necessity and as authorized by payment source)

Psychotherapy
- ☐ Individual
- ☐ Family
- ☐ Group

Rehabilitative Services
- ☐ Basic Skills Training
- ☐ Psycho-Social Rehabilitation

Biofeedback/neurofeedback
- ☐ QEEG Evaluation
- ☐ Sessions

REASON FOR SEEKING SERVICES

Concerns:

Symptoms/Behaviors/Issues at Home:

Symptoms/Behaviors/Issues at School/Employment:

Symptoms/Behaviors/Issues in the Community:

Would you like monthly update?

Please attach any relevant information you might think is necessary.