

**All About You Counseling and Support Services**

**Referral for services**

6070 South Eastern Ave. Suite 200

Las Vegas, NV. 89119

Phone: 702- 292-3774

**Client Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**SSN:** \_\_\_\_\_ **Medicaid #:** \_\_\_\_\_

**Client Address:** \_\_\_\_\_

**Attending School:** Yes ( ) No ( )

**School Name:** \_\_\_\_\_ **School Number:** \_\_\_\_\_

**Legal Guardian name(s):** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

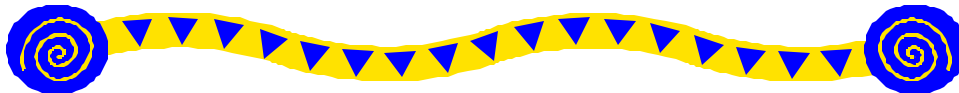
**Treating Physician:** \_\_\_\_\_

**Referral Source:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Hospital treated at:** \_\_\_\_\_

**Most recent Hospitalization date:** \_\_\_\_\_

**Suicidal Ideation:** Yes ( ) No ( ) **Danger to Self/Others:** Yes ( ) No ( )



**Recommended Services:** (Please check all that apply)

- Individual/Family Counseling
- School Re-entry
- Rehabilitative Services
- Basic Skills Training
- Support Group/Therapy
- Psychiatric Services
- Psychological Testing

**Presenting Issues/Additional information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By signing this form I acknowledge and agree to allow my information to be released to All about You Counseling and Support Services. I agree that I am requesting services on the behalf of my child.

\_\_\_\_\_  
Signature of Parent and/or Legal Guardian

\_\_\_\_\_  
Date

For fastest response please email referrals to: [services@allaboutyoutherapy.com](mailto:services@allaboutyoutherapy.com) or fax: 702-735-8431