HEALTHY MINDS

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Healthy Minds Referral

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Client Information		
Today's Date:	Date of Birth:	☐ Male ☐ Female ☐ Other: Specify _____
First Name:	Last Name:	
Cell phone:	Home phone:	Work phone:
Street Address:		
City:	State:	Zip Code:
Email:		
Employer:	School:	
Primary Language of Client: ☐ English ☐ Spanish ☐ Other: Specify _____ of Legal Guardian: ☐ English ☐ Spanish ☐ Other: Specify _____ Interpreter Needed?: ☐ Yes ☐ No		
Primary Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Decline to Answer Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Decline to Answer		
Check if this referral is for a ☐ current or ☐ previous Healthy Minds client ☐ N/A If so, please list the: Therapist _____ Psychiatrist: _____		
If the referred client is a minor, please select your relation: ☐ Biological-Parent ☐ Legal Guardian ☐ Foster Parent ☐ Adoptive Parent ☐ Person Legally Responsible ☐ Other: _____ ☐ Name: _____ *Please note that the legal guardian is responsible for medical/medication decisions and is required to be present for all intakes.* **If relation is other than the biological parent please bring documentation that you are legally responsible for this client (e.g. birth cert., adoption decree).**		
Marital Status of Legal Guardian: ☐ Single ☐ Married ☐ Re-Married ☐ Separated ☐ Divorced ☐ Widowed		

RETURN TO:
INTAKE.COORDINATOR@HEALTHYMINDSLV.COM
(702) 455-4629

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Referral Type

Check all that apply:

☐ Therapy ☐ Psychiatry ☐ DCFS-Med Clinic ☐ DCFS-MCRT ☐ SUD
☐ Telehealth ☐ Group Therapy* ☐ Healthy Homes * ☐ Psychological Testing*

Referral Source: _____

**Referrals to these programs require an additional referral document*

***If referred by DCFS for psychiatric services, please provide the most recent psych intake & last 3 psychiatric notes if applicable.*

Treatment History: Psychiatry

Has the client been treated by a Psychiatrist previously? ☐ Yes ☐ No (*Skip section if No)*	
Psychiatrist Name:	Diagnosis:
Phone:	Email:
Current Psychotropic Medications (*Please list all current medications*):	
Past Psychotropic Medications:	

Treatment History: Therapy

Has the client been treated by a Therapist previously? ☐ Yes ☐ No (*Skip section if No*)	
Therapist Name:	Diagnosis:
Phone:	Email:

Treatment History: SUD

Has the client been treated for Substance Use Disorders previously? ☐ Yes ☐ No (*Skip section if No*)	
Provider Name:	Treatment Components:
Phone:	Email:

Payment

☐ Fee-for-Service Medicaid Medicaid Number: _____
☐ Other Insurance: _____ Policy Number: _____
Group Number: _____

Client/Guardian will pay Healthy Minds directly if selecting one of the options below:
☐ Other Insurance ☐ Uninsured

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Presenting Problem

What is the problem that led you to seek services from Healthy Minds?