



[WWW.HEALTHYMINDSLV.COM](http://WWW.HEALTHYMINDSLV.COM)

## Healthy Minds Referral

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Client Information		
Today's Date:	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: Specify _____ of Legal Guardian: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: Specify _____		
Interpreter Needed?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Decline to Answer		
Ethnic Origin: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer		
Check if this referral is for a <input type="checkbox"/> <u>current</u> or <input type="checkbox"/> <u>previous</u> Healthy Minds client <span style="float: right;"><input type="checkbox"/> N/A</span>		
If so, please list the: Therapist _____ Psychiatrist: _____		
If the referred client is a minor, please select your relation: <input type="checkbox"/> Biological-Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Person Legally Responsible <input type="checkbox"/> Other: _____ <input type="checkbox"/> Name: _____ <i>Please note that the legal guardian is responsible for medical/medication decisions and is required to be present for all intakes.</i> <i>*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).*</i>		
Marital Status of Legal Guardian: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Re-Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		

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

## 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: \_\_\_\_\_

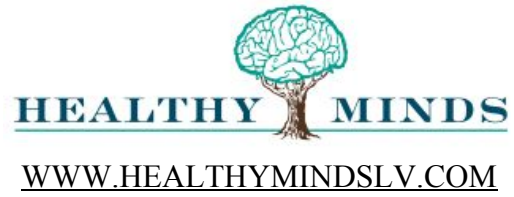
Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

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

☐ Other Insurance    ☐ Uninsured

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



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

**Presenting Problem**

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

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

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