REFERRAL

REFER@UCFNV.ORG

Referral Source:

Agency ________________________________ Contact Person __________________________

Address _______________________________ Phone__________________________________

Fax ___________________________________ Email _________________________________

Client Information:

Child's Name _______________________________ DOB _____________ Student ID__________________

Parent/Guardian _______________________________ Relationship ___________________________________

Address ____ Phone ______________________________

Parent's Preferred Language ☐English ☐Spanish ☐Other

Current Legal Entanglements: ☐YES ☐NO If Yes, Please Explain ____________________________________

Is Client Insured? ☐Yes ☐No ☐Don't know Insurance Name_____________________ Member ID ____________

Have the Parents/Legal Guardian been notified about the Referral? ☐YES ☐NO

Is Client seeing another Therapist? ☐Yes ☐No Therapist Name_______________________________________

Reason for Referral____

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Please turn in to intake personnel.
Thank You

Office Only

Referral Update:

Contact Made with Client ☐Yes ☐No Date of Contact _____________________

Scheduled Appointment Made ☐Yes ☐No Date of Appt. ______________________

Point of Contact Information:

Agency: (UCF) United Citizen Foundation

Address: 2048 N. Las Vegas Blvd. 89030

Contact Person ____________________________

Phone: 702-888-6300

Fax: 702-933-1041

Email: WWW.UCFNV.ORG

Comments:

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