Summit Mental Health

2810 W. Charleston Blvd. Suite 77, Las Vegas, NV 89102

Referral Form

DATE OF REFERRAL: _____

REFERRAL SOURCE:

Name:	
Relationship/Agency:	
Phone #:	
Guardian (if not same as above):	
Phone #:	
Relationship:	

CLIENT INFORMATION:

Name:		
Address:		
City:	**State:**	**Zip:**
Phone#:		
Insurance Provider:	**Provider Number:**	
Birth date: (MM/DD/YY) / /		

REASON FOR SERVICES:

Depression ☐	**Anxiety** ☐	**Coping Skills** ☐	**Sexual Abuse** ☐	**Trauma** ☐
ADHD ☐	**Phobias** ☐	**Grief/Loss** ☐	**PTSD** ☐	**Anger** ☐
Defiance ☐	**Self Esteem** ☐	**Social Skills** ☐	**Communication** ☐	**Parenting** ☐

ADDITIONAL INFORMATION:

SERVICES REQUESTED

Assessment ☐	**PSR** ☐ **BST** ☐	**Ind. Therapy** ☐	**Family Therapy** ☐	**Group Therapy** ☐
Medication Management ☐	**Other** ☐ please explain:			

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