Nevada Children's Center

CLIENT REFERRAL FORM

Thank you for considering Nevada Children's Center for your client's needs. If you have interest in learning more about our program or discussing your client's needs, please complete this form. Each client referred to us will receive a complete assessment to verify service needs. Upon completion of the assessment and approval from Medicaid, our Social Work department will develop a treatment plan and determine an appropriate course of action.

Referring Office: ____

Whom may we thank for this referral? ____

Client Name: ____ Date of Birth: __________

Client Address: ____

Telephone/Contact Number: ____________________________ Medicaid Recipient ID: _____________

Parent/Guardian Name(s): ____

SYMPTOMS AND/OR SIGNIFICANT LIFE EVENTS:

Please list symptoms and/or significant life events that relate to the client's diagnosis (pertinent family history, developmental history, medical issues, history of abuse, neglect, etc.)

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Nevada Children's Center abides by all HIPAA regulations and requirements. All information shared will remain confidential and will only be used to provide the best care possible for your client.

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