



REFERRAL FORM — GENERAL YOUTH

Please complete this form and return by email to supportiveservices@fmhwc.org. Questions? Call us at 702-731-0909.

REFERRAL SOURCE INFORMATION

Referral Date: _____
Referring Agency Name: _____
Referring Person Name: _____ Referring Person Title: _____
Phone Number: _____ Email: _____
Street Address: _____
City/State/Zip: _____
Have other referrals been made? Yes No If yes, to whom and what for: _____

CLIENT DEMOGRAPHICS

Client Name: _____ Client Date of Birth: _____
Phone Number: _____ Home Office Cell Phone Number: _____
Willing to receive text messages regarding appointment? Yes No
Email Address: _____
Street Address: _____
City/State/Zip: _____
Gender: Male Female Transgender Other
Race: American Indian/Alaska Native Asian Black/African American Hispanic/Latino
 Native Hawaiian/Other Pacific Islander White Non-Latino/Caucasian Other
Is there a need for an interpreter? Yes No If yes, state language: _____

PARENT/LEGAL GUARDIAN INFORMATION

Parent/Legal Guardian Name: _____
Phone Number: _____ Home Office Cell Phone Number: _____
Is there a need for an interpreter? Yes No If yes, state language: _____

SERVICES REQUESTED

Primary Care Service Behavioral Health Services Psychiatric Services
 Case Management Services (select all that apply):
 Housing Assistance Utility Assistance
 Food Pantry Transportation Assistance
 Employment/Job Training Insurance/Enrollment Assistance

REASON FOR REFERRAL

400 Shadow Lane, Suite 106, Las Vegas, Nevada 89106 • Fax 702-826-4757

3343 S. Eastern Avenue, Las Vegas, Nevada 89169 • Fax 702-731-1020

3940 N. Martin Luther King Boulevard, Suite 105B, North Las Vegas, Nevada 89032 • Fax 702-724-1978

Main Line 702-731-0909 • www.fmhwc.org • supportiveservices@fmhwc.org

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