Raise Up Nevada
1-866-359-6713
For any questions please call 775-688-0463 (Reno)
Please fax referrals 775-688-2171 to or scan referrals to vlpratt@health.nv.gov

Client Information

Client Name: _____ **Date of Birth:** _____ **Age:** _

Client's Address: _____

Contact Number: _____ **Alternate Number:** _____

What is the client's gender? Check ONE only:

__Female _Male _ Transgender (Male to female) _Transgender (Female to Male)
_Intersex _ Other

Ethnicity: Hispanic _ Non-Hispanic **Race:** _____

Parent/Legal Guardian Information

Parent/Legal Guardian Name(s): _____

Contact Number: _____ **Alternate Number:** _____

Is there a need for an interpreter? __Yes _No **If yes, language:** _____

Referral Source Information

Name: _____ **Program/Facility:** _____

Check One:
__Family Physician _ Nurse Practitioner _ Counselor _ Psychiatrist Self-Referral

__Parent or Legal Guardian _ Other Family Member (Please specify relationship): _____

Telephone Number: _____ **Email Address:** _____

Address: _____

Date of Referral: _____

Reason for Referral (Current symptoms, presenting problems, history):

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Symptoms

Symptoms of psychosis within 18 months? ___Yes ___No ___Don't Know
If yes, When? _____

Prior History of Inpatient Care? ___Yes _ No ___Don't know

If yes, Where? _____

Does client have a family doctor? _Yes ___No _Don't know

If yes, Who? _____

Is client seeing a psychiatrist? _Yes _____No _ Don't know

If yes, Who? _____

Risk Issue	Check One	If yes, When? (DD/YYYY)
Suicidal/Homicidal ideation	—Yes __ No	
Details:		
Deliberate self-harm	—Yes __ No	
Details:		
Legal Involvement	—Yes __ No	
Details:		

Substance Use (current substances, amount, and frequency of use, etc.):

Is client taking any medication? ___Yes ___No ___Don't Know ***If yes, please indicate below***

Medication(s)	Current	Past	Dose/Frequency