Lifespan Behavioral Health

Taking Steps Together

REFERRAL FORM

Date_____/_____/_____

REQUESTED BY

Name_____

Location_____ Phone Number_____

PATIENT DATA

Patient Name_____ Date of Birth_____/_____/_____

Patient Phone_____ Email_____

Insurance_____

Please scan and email the completed form to intake@lsbhtherapynv.com

Or Fax to 725-715-2123

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