COMMUNITY AGENCY/SCHOOL REFERRAL FORM

Today's Date: ____

Referring Agency/School:_______________________________________

Youth's Name: ____

Date of Birth: ______________________ **Gender**: ____________________

Parent/Legal Guardian's Name: ___________________________________

Relationship to the Child: _______________________________________

Address: ____

Phone Number: ________________________ **Best time to call:** __________

Email Address:____

Reason for Referral: ____

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Name of person making the referral:_______________________________

Email: ____

Direct phone number: ____

Please fax to 702-455-6913 or email to mail@theharborlv.com