LA FRONTERA
NEW MEXICO
Your partner for a safe, strong, and healthy community.

Referral For Services

Form to be filled out, signed and return via e-mail or fax.
LFNMReferral@lafrontera.org
Fax: (575) 647-2898

First & Last Name _____ Social Security Number _____ Date of Birth _____

Address, City, Zip _____ Phone Number _____

Name of Referring Party / Agency Representing _____ Date _____

Referral Contact Phone Number _____

Reason For Referral

- ☐ Academic Problems
- ☐ Anger Management
- ☐ Behavior Problems in School
- ☐ Boundaries
- ☐ Eating Disorder
- ☐ Family
- ☐ Impulsivity
- ☐ Independent Living Skills
- ☐ Life / Social Skills
- ☐ Oppositional Defiance
- ☐ Parenting Skills
- ☐ Peer Influence
- ☐ Poor Judgment
- ☐ Problem Solving
- ☐ Relationships
- ☐ Screening
- ☐ Self-Esteem
- ☐ Self-Harming Behaviors
- ☐ Sexual Assault/Abuse
- ☐ Sexual Promiscuity
- ☐ Other

Substance Abuse Type (If applicable): _____ Positive Urinalysis Dates: _____

Please Describe Referral Situation: _____

Other services currently receiving: _____

_____ Where: _____

Release Of Information

I, _____ authorize La Frontera New Mexico to report to personnel from referring agency information for the purposes of coordinating care for this referral only.

I can revoke this consent at any time, but that will not affect any information during my treatment that has already taken action relying on this release. I also understand that any disclosure made is bound by part 1 of Title 42 of the Code of Federal Regulations governing confidentially of alcohol and drug abuse patient records and those recipients of this information may re-disclose it only in connection with their official duties. This authorization to use protected health information will expire one year from the date signed below, or upon the completion of treatment at La Frontera New Mexico, whichever shall first occur.

Signature _____ Date _____

Parent/Guardian Signature (If applicable) _____ Date _____

Witness _____ Date _____