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**SMYAL Adult Clinical Services**

**Referral Form**

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| **Client name:**  | **DOB:** | **Age:**  | **Pronoun/Pronouns:** |
| **Client Cell #:**  | **Client Email:**  |
| **Address:**  | **Ward:**  | **Zip code:**  |
| **Referral Source:** | **Referral Source phone:** | **Referral Source email:**  |
| **Date of Referral:** |  |  |  |
| **Relevant issues and concerns:**[ ]  **Depression** [ ]  **Anxiety**[ ]  **Behavioral Problems**[ ]  **Difficulty concentrating** [ ]  **Abnormal Eating Behaviors**[ ]  **Trauma symptoms/flashbacks/prior abuse**[ ]  **Developmental concerns**[ ]  **Psychosis**[ ] **Domestic Violence**[ ] **Transgender concerns**[ ] **Identity concerns**[ ]  **Other (please specify):**  | **Urgency:****Danger to others**[ ]  **None** [ ] **Mild** [ ] **Moderate** [ ]  **Severe** **Psychotic Symptoms** [ ]  **None** [ ] **Mild** [ ] **Moderate** [ ]  **Severe** **Substance Abuse**[ ]  **None** [ ] **Mild** [ ] **Moderate** [ ]  **Severe** **Non-Suicidal Injury**[ ]  **None** [ ] **Mild** [ ] **Moderate** [ ]  **Severe** **Suicidal Ideation**[ ]  **None** [ ] **Mild** [ ] **Moderate** [ ]  **Severe** **Suicidal Attempt**[ ]  **None** [ ] **Mild** [ ] **Moderate** [ ]  **Severe** **Suicide Plan**[ ]  **None** [ ] **Mild** [ ] **Moderate** [ ]  **Severe**  |
| **Functionality:****Problems with Social/friendships/community/interest**[ ]  **None** [ ] **Mild** [ ] **Moderate** [ ]  **Severe** **Problems with School or Work**[ ]  **None** [ ] **Mild** [ ] **Moderate** [ ]  **Severe** **Problems with Family** [ ]  **None** [ ] **Mild** [ ] **Moderate** [ ]  **Severe**  |  |
| **Background/ Brief Social History (reasons for therapy):** |
| **Services Offered:****Therapy Services:**[ ] Individual Therapy[ ] Family Therapy  |  |
| **Desired Outcome:(what would you like to accomplish in therapy)** |