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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)** | | | | | | | |