empowering LGBTQ youth

SMYAL Youth Clinical Services Referral Form

Youth's name:	DOB:	Age:	Pronoun/Pronouns:
Gender Identity:	Race:		
Youth's Cell #:	Youth's Email:		
Parent/Guardian name:	Relationship to youth:		
Address:	Ward:	Zip code:	
Home phone:	Parent/Guardian Cell #:	Parent/Guardian Email:	
School:	Grade:	Health Insurance:	
Referral Source:	Referral Source phone:	Referral Source email:	
Date of Referral:			

Relevant issues and concerns:

☐ Depression
☐ Anxiety
☐ Running Away
☐ Truancy
☐ Behavioral Problems
☐ Attention/Hyperactivity
☐ Abnormal Eating Behaviors
☐ Trauma symptoms/confirmed findings of physical/sexual abuse or neglect
☐ Developmental concerns
☐ Psychosis
☐ 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

410 7th Street SE Washington DC
(202) 546-5940 (phone)

	Suicide Plan ☐ None ☐Mild ☐Moderate ☐ Severe

Functionality:

Problems with Social/friendships/community/interest
☐ None ☐Mild ☐Moderate ☐ Severe

Problems with School
☐ None ☐Mild ☐Moderate ☐ Severe

Problems with Family
☐ None ☐Mild ☐Moderate ☐ Severe

Background/ Brief Social History:

Recommended Service and Provider:

Therapy Services
☐Individual Therapy
☐Family Therapy

Desired outcomes for youth/family (i.e. Why did you select this specific service and service provider):