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**STUDENT REFERRAL FORM**

Relationship to person being referred: \_\_\_\_\_  
 Date \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

**Information of Person Being Referred:**

Date \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex (M/F) \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_  
 Parent[s] or Guardian[s] Name [first & last]: \_\_\_\_\_

May I contact you by email for scheduling purposes? \_\_\_\_\_  
 Email Address: \_\_\_\_\_

<b>Local Phone</b> _____	<b>Can I call you here?</b> _____	<b>Can I leave a message?</b> _____
<b>Cell Phone</b> _____	<b>Can I call you here?</b> _____	<b>Can I leave a message?</b> _____

Current school: \_\_\_\_\_ Grade level: \_\_\_\_\_  
 Previous schools attended: \_\_\_\_\_

**Please check any current or past issues that still affect you:**

- |  |   |
|--|---|
| <input type="checkbox"/> Eating Disorders  | <input type="checkbox"/> Pregnancy Issues       |
| <input type="checkbox"/> Academic Issues   | <input type="checkbox"/> Spiritual Concerns     |
| <input type="checkbox"/> Childhood Abuse (i.e. physical, sexual, emotional)          | <input type="checkbox"/> Depression             |
| <input type="checkbox"/> Stress/Anxiety  | <input type="checkbox"/> Pornography            |
| <input type="checkbox"/> Phobias (type: _____)                                       | <input type="checkbox"/> Sexual Identity Issues |
| <input type="checkbox"/> Alcohol/Other Drug Use                                      | <input type="checkbox"/> Relationship Concerns  |
| <input type="checkbox"/> Sexual Assault/Rape   | <input type="checkbox"/> family                 |
| <input type="checkbox"/> _____ recently (when: _____)                                | <input type="checkbox"/> friend                 |
| <input type="checkbox"/> _____ in the past   | <input type="checkbox"/> parent                 |
| <input type="checkbox"/> Death of a someone close                                    | <input type="checkbox"/> significant other      |
| <input type="checkbox"/> _____ recently (when: _____)                                | <input type="checkbox"/> roommate               |
| <input type="checkbox"/> _____ in the past   | <input type="checkbox"/> other: _____           |
| <input type="checkbox"/> Family Issues (i.e. divorce, alcoholism, domestic violence) | <input type="checkbox"/> Suicidal Thoughts      |
| <input type="checkbox"/> Other: _____  |   |

**Please check any previous interventions:**

- |  |  |
|--|--|
| <input type="checkbox"/> Individual Counseling     | <input type="checkbox"/> School observations/testing |
| <input type="checkbox"/> Group Counseling          | <input type="checkbox"/> Tutoring                    |
| <input type="checkbox"/> Medication                | <input type="checkbox"/> Inpatient Treatment         |
| <input type="checkbox"/> Psychological Assessments | <input type="checkbox"/> Other _____                 |

**Additional information/explanation [optional]:** \_\_\_\_\_