SBS Form C © 6/15

Please send completed forms to:
Step By Step Attn: Intake
1470 Beacon Street, Suite B, Brookline, MA 02446
617-277-6140 (P) 617-277-0168 (F)
Please call or e-mail referralinfo@stepbystepss.org
With any additional questions

Clinician Referral Form

The applicant's therapist, psychiatrist, social worker, case manager, or other clinician should fill out this form.

*Please also submit any psychological evaluations and a signed release of information from the patient

Name and title of Clinician: ____
Phone #: ____
Address: ____
Length of contact: ____
Location of contact: ____

Applicant's name: ____
Address: ____
____
Phone number: ___________________ D.O.B.:___________________
SS#: _________________

Marital Status: ☐ Married ☐ Single/Never married ☐ Separated
☐ Divorced ☐ Cohabitating ☐ Widowed

Sexual orientation: _____________________________________

DSM-5 DIAGNOSIS:
____
____
____
____

PSYCHIATRIC HISTORY

Current mental status:

____
____
____
____

History of psychiatric/therapeutic treatment:

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Hospitalizations:

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Does the applicant have a history of any of the following?

Suicidal/Homicidal Behavior? □ Yes □ No

Self-Injurious Behavior? □ Yes □ No

Sexually Inappropriate Behavior? □ Yes □ No

Aggressive or Assaulting Behavior? □ Yes □ No

Substance Abuse? □ Yes □ No Date of last use: ____________________

If you answered YES to any of the questions above please explain:

____
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____

Current living situation: □Alone □Family □OTHER (Please Explain)

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____
____
____

Is the applicant able to perform the following ADL'S?
*** (IF NO, Please describe limitations)

Toilet self □ Yes □ No ______________________
Bathing □ Yes □ No ______________________
Brushing teeth □ Yes □ No ______________________
Dressing □ Yes □ No ______________________
Feeding self □ Yes □ No ______________________
Laundry □ Yes □ No ______________________

Does the applicant have any problems with incontinence? □ Yes □ No

Has the applicant ever been arrested or been convicted of a crime? □ Yes □ No
(If Yes, Please explain and provide dates)

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What are the goals for the applicant's involvement with SBS?

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Suggested length of services: □3-6 Months □ 6-12 Months □ More than 12 Months

Medical history: (please attach records if applicable)

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____
____

Please list any communicable disease_______________________________

Height: _________ Weight: _________ Date of last Tetanus: _____________ PPD:_____________

Has there ever been a head injury: □ Yes □ No History of seizures: □ Yes □ No

Major surgeries:

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____

Limitations to physical activity:

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Please list any allergies:

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____

CURRENT MEDICATIONS: (use additional sheet if necessary)

Medication	**Dose**	**Route**	**Schedule**	**Prescribing Dr.**

Clinician's signature: ____ Date: __________