



## Galia Wellness Services

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### Self Referral Form

## Galia Wellness Services

Self Referral Form – Psychotherapy Services

#### Important Notice:

Galia Wellness Services offers outpatient psychotherapy and is not a crisis or emergency service.

If you are in immediate danger or need urgent support, please contact local emergency services or your local Northern Regional Health Authority crisis resources right away.

Submitting this form does not automatically confirm services; you will be contacted directly to complete the intake process and review informed consent before beginning therapy.

#### Client Information

Client Full Name : \_\_\_\_\_

Preferred name (if applicable): \_\_\_\_\_

Date of Birth (YYYY-MM-DD): \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

#### Voice Mail (*Select only one*)

Voicemail permitted

Voicemail NOT permitted

Emergency Contact (name & phone number): \_\_\_\_\_

Parent / Guardian Name (if under 18): \_\_\_\_\_

Parent / Guardian Phone number: \_\_\_\_\_

## Presenting Concerns

Primary Concerns (brief summary)

Relevant Diagnosis (if applicable)

Therapy Goals (if known)

Anything you'd like the Therapist to know?

## Risk Screening

Current Risk Status (*Select all that apply*)

- No safety risk
- past or recent suicidal ideation
- history of self harm

Safety Plan (*Select only one*)

- Safety Plan in place (copy available)
- Safety Plan NOT in place

Recent hospitalizations (if applicable, past 6 months)

### **\*PLEASE NOTE\***

If active or imminent risk is present, referral acceptance may be deferred pending stabilization through appropriate emergency services.

## Current Supports

Current Mental Health Providers

Primary Care Provider (if known)

Current Medications (if relevant)

### Confirmation (*Select only one*)

- I confirm understanding that Galia Wellness Services is an outpatient psychotherapy provider and not a crisis service.
- Contact requested for clarification

Client Name: \_\_\_\_\_

Date (YYYY-MM-DD): \_\_\_\_\_