COUNSELING REFERRAL FORM

Date of Referral: _____ Person Making Referral: _____

Relationship to Student: _____ Contact Information: _____

STUDENT INFORMATION

Name: _____ Date of Birth: _____ Gender: ☐ Female ☐ Male

Address: _____ City: _____ Zip Code: _____

Ethnicity: _____ Primary Language: _____

Name of School: _____ Grade in School: _____

Teacher: _____ School Phone Number: _____

Parent/Guardian: _____

Parent/Guardian Telephone: _____ Parent Email: _____

Is this student receiving Special Education Services? ☐ Yes ☐ No

REASON FOR COUNSELING REFERRAL

Presenting Concerns (Please give examples of statements, observations, or behavior that led you to make this referral.)

_____

_____

Goals of Counseling (What are some of the goals you would like to see accomlishded through counseling services?)

_____

_____

Strengths (Please list the strengths of this child and his/her family.)

_____

_____

Previous Interventions (Has anything been tried to address this concern(s) If so, please list here.):

_____

_____

Type of Insurance

☐ AHCCCS/KidsCare AHCCS/KidsCare ID#: _____ ☐ Private Insurance ☐ None at this time

Parent/Guardian Consent

☐ I, as parent/guardian of this child, give my consent to make this counseling referral.

☐ I, as a school staff memember, have discussed my concerns with the parent/guardian and verbal permission was given to make this counseling referral.

Signature: ☐ Parent/Guardian ☐ School Staff Member

_____ _____

Signature Date

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