Counseling Referral Form

Date of Referral: _____ Person Making Referral: _____

Relationship to Student: _____ Contact Information: _____

Student Information

Name: _____ Date of Birth: _____ Gender: M F

Address: _____ City/State/ZIP Code: _____

Email Address: _____ Primary Language: _____

Parent/Guardian Name: _____ Phone Number: _____

Name of School: _____ Grade in School: _____

Teacher: _____ School Phone Number: _____

Is this student receiving Special Education Services? Y N (please attach copy of IEP)

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 accomplished 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)? Please list here)

_____

_____

Type of Funding

☐ AHCCCS AHCCCS ID #: _____

☐ Other Insurance ☐ Uninsured

Parent/Guardian Consent

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

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

Signatures

☐ Parent/Guardian

☐ School Staff Member

_____ _____

Signature Date Send completed referral forms:

Send completed referral forms: childrensdepartment@terroshealth.org