SUMMIT ONSITE
SCHOOL-BASED THERAPY

The School's Parent Agreement MUST be completed to move forward with service, Please email to schoolbasedservices@SummitCounseling.org and/or your Summit OnSite therapist

Therapy Services Referral Form

Student Information

Date: _____ Age: _____ Gender: _____ Ethnicity: _____

Student's Name: _____ Birth Date: _____

Health Insurance Y/N: _____ Insurance Type: _____ Policy Number: _____

Your Name: _____ Email Address: _____ Phone Number: _____

Relationship to Student: ☐ Parent/Guardian ☐ Grandparent/Great Grandparent ☐ Other: _____

School Information

School: _____ Grade: _____ Homeroom Teacher: _____

Reasons for Referral (Check All That Apply)

- ☐ **Academic Performance**
- ☐ **Classroom Conduct**
- ☐ **Behavior (outside of school)**
- ☐ **Trauma**
- ☐ **Suicidal Thoughts and/or Plans** ☐ Current ☐ History
- ☐ **Self-Harm** ☐ Current ☐ History
- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Grief/Loss**
- ☐ **Family/Community Related Concern**
- ☐ **Drug and Alcohol Use**
- ☐ **Health and Wellness Concerns** (Please explain in "Additional Comments" section below)
- ☐ **Other** (Please Indicate): _____

Referral Source – Who is Requesting Services

☐ Student (Self-Request)	☐ Teacher	☐ School Counselor
☐ Parent/Guardian	☐ School Social Worker	☐ School Administrator
☐ DFACS or DJJ	☐ Other: _____	

Name: _____ Email Address: _____ Phone Number: _____

Additional Comments about Student Behavior or Symptoms: