Therapeutic Services Referral Form

Student Information

Date: Age: Gender: Select Below Ethnicity: Select Below

Student's Name: Birth Date: ****SS#:**

Guardian Name: Address: Phone Number:

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

***** Social security is needed to check insurance. Families can choose to discuss with therapist, if preferred.***

School Information

School: Grade: Select Below Homeroom Teacher:

Does the student have a 504 Individualized Accommodation Plan or Individualized Education Program?

☐ 504 Plan ☐ IEP

Reasons for Referral (Check All That Apply)

☐ **Academic Performance** ☐ **School Conduct Concerns** ☐ **Peer Conflict**

→ Frequency: (#) times per ☐ Day ☐ Week ☐ Month

→ Previous Actions Taken: (Please check below)

- ☐ Behavioral Plan
- ☐ Caring Adult in the Building (CAB)
- ☐ Classroom Changes
- ☐ Classroom Interventions
- ☐ Opportunity Gap/Restorative Room
- ☐ Parent Notification/Involvement
- ☐ Peace Corner/Cool Down Room
- ☐ Previous Mental Health Counseling
- ☐ Other: _____

☐ **Behavior (outside of school)**

☐ **Trauma**

☐ **Suicidal Thoughts and/or Plans** ☐ Current ☐ History

→ **Was the school social worker notified?** ☐ Yes ☐ Contacted- no response ☐ No

☐ **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): _____

Additional Comments about Student Behavior or Symptoms

_____

Referral Source – Who is Requesting Services?

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