Emergence Health Network

School Counselor Referral Form
EHN School-Based Services
(To be completed by school counselor)

Date of Referral:	

COUNSELOR INFO

Counselor Name:			
Phone Number:		**Email Address:**	
School District:		**Campus**:	

INITIALLY REFERRED BY (IF APPLICABLE)

School Staff Name:		**Email Address:**	
Relationship to Student: ☐ **Principal** ☐ **AP** ☐ **Teacher** ☐ **Nurse** ☐ **Coach** ☐ **Other:**			

STUDENT INFO

Student Name:		**Student Date of Birth:**	
Grade:		**Student ID Number:**	
Student Cell Phone Number:		**Student Preferred Language:**	
Is the student agreeable to mental health services? YES NO			
Is the student in DAEP? YES NO			
Is the student in Special Education, 504, IEP, etc.? YES NO			

PARENT/GUARDIAN INFO

Parent/Guardian Name:		**Relationship to Student:**	
Parent/Guardian Phone Number:		**Alternate Contact:**	
Parent/Guardian Home Address:			
Parent/Guardian Email Address:		**Parent/Guardian Preferred Language:**	
Is the Parent/Guardian agreeable to services? YES NO			
Does the parent/guardian commit to attending sessions as needed? YES NO			

Reason for Referral:
Please describe reason for referral (information and/or concerns):

___ Changes in mood at home or at school
___ Feeling very worried, nervous, or anxious
___ Experienced/experiencing a loss or death
___ Experienced/experiencing abuse or trauma
___ Sexual/gender identity issues
___ Aggressive or violent at home or school
___ Trouble adjusting to a change at home or school
___ Eating disturbances
___ Substance misuse
___ Suicidal Ideations
___ Self-harming behaviors
___ Other: _____

Notes:_____
_____

Thank you! Please email completed form to sbmh@ehnelpaso.org