River Valley Counseling Center

School-Based Therapy Referral

School District or Town: _____ School Name: _____

Referring Person: _____ Date: _____

STUDENT INFORMATION

Name: _____DOB: _____ Age:____ Grade: ____ Gender:_____

Address(es):_____

Parent/Guardian A: _____ Relationship: _____

Phone#: _____ Email: _____

Parent/Guardian B: _____ Relationship: _____

Phone#: _____ Email: _____

Primary Language of Parent(s)/Guardian: __ English __ Spanish __Other/Notes: _____

Reasons for Referral:

__ Adjustment to Trauma
__ Anxious
__ Depressed Mood
__ Hyperactive/Impulsive
__ Inattentive
__ Emotional Outbursts __
Physically Aggressive __
Oppositional/Defiant __
Frequent Social Conflicts __
Suicide Risk
__ Self Harm/Injury
__ School Work Avoidant
__ Disruptive in Class
__ Social Skills Development
__ Grief & Loss
__ Target of Bullying
__ Family Stress
__ Parental Separation/Divorce
__ Personal Hygiene
__ Eating Disturbance
__ Frequent Physical Complaints
__ Substance Use
Other reasons or additional info:

HEALTH INSURANCE *Therapy services are billed to the child's health insurance plan(s). The parent/guardian is responsible to pay RVCC any out of pocket expenses that are required by the health insurance plan (ie: copays, co-insurance, and/or deductibles). Questions regarding billing or payments can be discussed with the child's assigned therapist.*

- Masshealth; Policy Name & Number (if known):_____
- Private/Commercial Insurance; Policy Name/Number (required):_____
  Policy Holder Name: _____ Relationship to Client: _____
  Policy Holder Address:_____
- Other Insurances (if any, with policy number):_____

For all private/commercial insurances, a copy of the front and back of the insurance card must be included with the referral.
Please also include copies of masshealth insurance cards whenever possible.

RELEASE: I hereby authorize the School/District identified above to release information about my child to River Valley Counseling Center, Inc. (RVCC). I also authorize the School/District to allow my child to see a therapist from RVCC at their school for the purpose of receiving therapy. I understand that I may withhold authorization at any time. This consent and authorization are valid for the full course of this treatment episode. I am

the parent/guardian of:_____Signed:_____Date: _____

-OR- School Staff: I have read the above authorization to the parent/guardian and verbal consent was obtained.

Person Completing Form: _____Parent/Guardian Name: _____ Date: _____

At the intake appointment, the therapist will discuss implementing a more thorough release of information between RVCC and the school.

School Staff: RVCC is a member of ServiceNet as of 7/1/2025. Please email form to RVCC Central Intake: rvccintakeschools@servicenet.org and Cc designated Director/Coordinator. Questions? RVCC Central Intake Phone: 413-540-1234

Updated 8/1/25 A.M.