**SCHOOL COUNSELING REFERRAL FORM**

Please complete the following and send this form, and any additional information to:

office@empoweringchoicescc.com or fax **to: 503-589-3179**

**ATTN: Front Desk, Office number: 503-589-3112**

805 Liberty St NE Suite 2 Salem, OR 97301

Teacher/School:

Phone Number:

Email:

|  |
| --- |
| **Referring**  Students Name: Grade:  Date of Birth/Age:  Students Address:  City/State/Zip:  Insurance Type:  Policy Number (s):  Parent or Caretaker Name:  **Demographics** |

Requested Services (Mark all that apply)

Assessment (With Services – Specify Services Desired Below)

Child  Siblings  Parent/Child  Family

Assessment (With Recommendations Only, No Services)

Child  Siblings

Reason for referral to counseling:

Has difficulty making and keeping friends?

Has difficulty accepting responsibility for actions?

Has difficulty making decisions?

Has a hard time staying on task?

Has a hard time adjusting to new situations?

Has difficulty respecting authority?

Is shy and withdrawn?

Appears to worry a lot?

Does not complete tasks?

Is absent a lot?

Possible difficulty with family relationships?

Referring Person/Agency: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

Email: Click or tap here to enter text.

Requested Services (Mark all that apply)

Services Requested (assessment required; services based on medical necessity and as authorized by payment source)

Psychotherapy/Counseling Family Support (consultation) Assessments

Individual  Life skills  Psycho-Social

Family  Social Skills  Autism

Group  Asperger’s Syndrome

Understanding the Autism Spectrum

Play Therapy How ADHD Affects the Family  Functional Assessment

Autism Therapy Parenting Coaching  ADHD/ADD

Examples of Behavior:

List of Strengths this student has:

Request to See the Counselor is Being Made By:

Student

Parent

Teacher

Principal

Other:

**THE REFERAL FORM MUST BE SIGNED BY THE PRINCIPAL**

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**Signature of Principal Signature of Parent**