SCHOOL-BASED COMMUNITY COUNSELING SERVICES
INITIAL REFERRAL FORM

STUDENT INFORMATION		
Student's Name:		
Referral Date:	Date of Birth:	Phone:
Current address:		
City:	State:	ZIP Code:
Legal Guardian: Parent Grandparent DCFS Other (specify):		

STUDENT DEMONGRAPHIC INFORMATION		
Sex: Male Female	Age:	Current Grade:
Race:	Ethnicity:	IEP/504?: Yes No

EMERGENCY CONTACT	
Name of Emergency Contact:	
Phone:	Relationship:

PARENT INFORMATION	
Parent #1 Name:	Parent #2 Name:
Address:	Address:
City:	City:
State: ZIP Code:	State: ZIP Code:
Place of Employment:	Place of Employment:
Marital Status:	Marital Status:

SIBLINGS	
Name: Age:	Name: Age:
Name: Age:	Name: Age:

REASON FOR REFERRAL (INCLUDING HISTORY OF SUICIDALITY/SELF-HARM AND FAMILY DYNAMICS INFORMATION):

VERBAL CONSENT TO SERVICES	
Name of parent/guardian contacted:	Date of contact and by whom:
Does parent/guardian consent to services: YES NO	Does parent understand this is a billed service: YES NO

OFFICE USE ONLY: INSURANCE INFORMATION	
Medicaid:	Medicaid Insurer:
Private Insurance:	Name of Policy Holder:
ID#:	Group #: