

Hope Springs Counseling Referral Form

Referral Information

Date of Referral:

Name of Referring Entity:

Contact Information:

Student Information

Student Name:

Date of Birth:

Grade Level:

School Name:

Parent/Guardian Information

Parent/Guardian Name(s):

Phone Number:

Email Address:

Reason for Referral (Check all that apply)

☐ Academic Concerns ☐ Behavioral Issues ☐ Emotional Support Needed

☐ Family Concerns ☐ Peer Relationships ☐ Trauma/Grief

☐ Other: _____

Previous Interventions

Has the student received counseling before? ☐ Yes ☐ No

If yes, where and when?

Additional Comments/Concerns:

Consent & Authorization

Parental Consent for Referral: ☐ Yes ☐ No

Signature of Referring Entity Representative: _____ Date: _____