Growing Young Minds

Counseling

Brittany Cephas, LCPC Mental Health Services, LLC

Client Referral from School Professional

Please print. Complete.

Date:_____

Student's Name:_____

Race: _____

DOB/Age: _____

Sex/Gender: _____

Name of School: _____

Teacher/Grade: _____

Parent's Name: _____

Parent's Phone: _____

Parent's Email: _____

PERSONAL / SOCIAL / EMOTIONAL CONCERNS

Reason for Referral:

Anger Management

Yes _____

No.

Family Conflict

Yes _____

No.

Bullying Concerns

Yes
_____

No.

Negative Attitude

Yes_____
_

No.

Social Skills

Yes_____
_

No.

Self-Esteem

Yes
_____

No.

Low Motivation

Yes
_____

No.

Grief/Loss

Yes
_____

No.

ADD/ADHD

Yes
_____

No.

Worry/Anxiety

Yes

_____

No.

Marked Sadness

Yes _____

No.

Please add additional information here:

ACADEMIC CONCERNS

*** Attendance**

Yes _____

No.

*** Underperforming/ Underachieving**

Yes _____

No.

*** Follow Rules and Expectations**

Yes _____

No.

Organizational Skills

Yes _____

No.

Your Name/Title: _____

Your Signature: _____

Phone: _____

Email: _____

* Does the client's parent/guardian know that you are making this referral?

Yes

No

What else would you like to share regarding this case?

Thank you for completing a referral for services! Next, please send this form to bcephas@grow-minds.com. You

will hear back from us within 1-2 business days upon us receiving the referral.