**Counseling Referral Form Template PDF**

**Client Information**

* **Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Gender: ☐ Male ☐ Female ☐ Other**
* **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Guardian (if minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for Referral  
☐ Depression/Anxiety  
☐ Self-Harm Concerns  
☐ Academic Difficulties  
☐ Behavioral Issues  
☐ Substance Abuse  
☐ Family Conflict  
☐ Trauma/PTSD  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Support System**

* **Parent/Guardian Support: ☐ Yes ☐ No**
* **Teacher/Staff Support: ☐ Yes ☐ No**
* **Peer Support: ☐ Yes ☐ No**

**Interventions Attempted  
☐ Classroom Modifications  
☐ Parent Meetings  
☐ Behavioral Plans  
☐ Special Education Assessment  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Recommended Next Steps**

* **Individual Counseling ☐ Yes ☐ No**
* **Group Counseling ☐ Yes ☐ No**
* **Family Counseling ☐ Yes ☐ No**
* **Referral to Specialist ☐ Yes ☐ No**

**Consent & Acknowledgment  
I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to the counseling referral and understand the process.**

**Client/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**Referring Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**