**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: \_\_\_\_\_\_\_\_\_\_\_**