9991 Commerce St.
Summerville, GA 30747
O: (678) 632-5152
C: (706)609-0404
F: (706) 603-0063

SCHOOL REFERRAL FOR COUNSELING SERVICES

SCHOOL INFORMATION

School Name:			County:
Representative Name:	Title:		
School Address:	City	State:	Zip:
Is the client/guardian aware of this referral? ☐ Yes ☐ No	Is this referral Urgent? ☐ Yes ☐ No		
Phone No:	Email:		
Representative Signature:	Date:		

STUDENT INFORMATION

First Name:	Last Name:		
Date of Birth:	Age:	Gender:	
Guardian Name *(if under 18)*:			
Address:	City:	State:	Zip:
Phone No:	Can we leave a message? ☐ Yes ☐ No		
Email:	Can we email? ☐ Yes ☐ No		

Parental Consent signed ☐ Yes ☐ No
Date_____

Reason for Referral? (*Select all that apply*)

- ☐ Abuse
- ☐ Academic
- ☐ Addiction
- ☐ Attendance
- ☐ Behavior
- ☐ DFACS
- ☐ Hygiene
- ☐ Economic
- ☐ Emotional
- ☐ Family Issues
- ☐ Gangs
- ☐ Grief / Loss
- ☐ Homeless
- ☐ Mental Issues
- ☐ Neglect
- ☐ Pregnancy
- ☐ Social Skills
- ☐ Self-Esteem
- ☐ Trauma
- ☐ Probation
- ☐ Truancy
- ☐ _____

☐ Individual Session ☐ Group Session

Prior Interventions:

School payment request/invoice ☐ Insurance billing/parent ☐

Insurance Carrier *(if applicable)*:	Insurance Number:

PLEASE EMAIL OR FAX THE COMPLETED REFERRAL FORM TO:

Email: talk@mindcare.us Fax: (706) 603-0063

MindCare Office Use Only: Case was ☐ Approved ☐ Denied ☐ Scheduled Date: _____ Initials: _____