SUMMIT ONSITE
SCHOOL-BASED THERAPY

The School's Parent Agreement MUST be completed to move forward with service, Please email to schoolbasedservices@SummitCounseling.org and/or your Summit OnSite therapist

Therapy Services Referral Form

Student Information

Date: ____________ Age: ____________ Gender: ____________________ Ethnicity: ____________________

Student's Name: ____________________ Birth Date: ____________________

Health Insurance Y/N: ____________________ Insurance Type: ____________________ Policy Number: ____________________

Your Name: ____________________ Email Address: ____________________ Phone Number: ____________________

Relationship to Student: ☐ Parent/Guardian ☐ Grandparent/Great Grandparent ☐ Other: _____

School Information

School: ____________________ Grade: ____________________ Homeroom Teacher: ____________________

Reasons for Referral (Check All That Apply)

- ☐ **Academic Performance**
- ☐ **Classroom Conduct**
- ☐ **Behavior (outside of school)**
- ☐ **Trauma**
- ☐ **Suicidal Thoughts and/or Plans** ☐ Current ☐ History
- ☐ **Self-Harm** ☐ Current ☐ History
- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Grief/Loss**
- ☐ **Family/Community Related Concern**
- ☐ **Drug and Alcohol Use**
- ☐ **Health and Wellness Concerns** (Please explain in "Additional Comments" section below)
- ☐ **Other** (Please Indicate): ____

Referral Source – Who is Requesting Services

☐ Student (Self-Request)	☐ Teacher	☐ School Counselor
☐ Parent/Guardian	☐ School Social Worker	☐ School Administrator
☐ DFACS or DJJ	☐ Other: ____________________	

Name: ____________________ Email Address: ____________________ Phone Number: ____________________

Additional Comments about Student Behavior or Symptoms: