Counseling Referral Form

Date of Referral: _____

Referral Agency Information

Referring Agency Name: _____
Referring Staff Contact Name & Title: _____
Phone Number: _____
Email Address: _____
Fax Number (if applicable): _____

Client Information (Child)

Full Name: _____ Date of Birth: _____
Age: _____
Address: _____
Sex/Gender Identity: _____
Race/Ethnicity: _____
Primary Language: _____
Interpreter Needed? ☐ Yes ☐ No
School (if applicable): _____
Grade: _____ Special Ed: _____

Parent/Guardian Information

Name(s): _____
Relationship to Child: _____
Sex/Gender Identity: _____
Race/Ethnicity: _____
Date of Birth: _____
Phone Number(s): _____
Email Address: _____
Custody Status: ☐ Full ☐ Joint ☐ None
Does the parent/guardian have legal authority to consent to services? ☐ Yes ☐ No

Referral Reason / Presenting Concerns

(Check all that apply)

☐ Trauma-related symptoms	☐ Adjustment difficulties
☐ Anxiety or depression	☐ Family conflict or domestic violence
☐ Behavioral concerns	☐ Suspected/Confirmed abuse
☐ Court preparation support	☐ Other: _____

Brief Description of Concerns:

Legal / Case Information

Is the case currently involved with:

☐ Child Protective Services	☐ Law Enforcement
☐ Court System	☐ Other: _____

Name of Investigating Agency (CPS/Law Enforcement): _____
Investigator/Caseworker Name & Contact Info: _____
Is there an active investigation or court case? ☐ Yes ☐ No
Protective Orders in place? ☐ Yes ☐ No
Are there safety concerns for staff (e.g., non-custodial parent)? ☐ Yes ☐ No
If yes, please describe:
_____

Requested Services

(Check all that apply)

☐ Individual Counseling for Child	☐ Family Therapy
☐ Parent Support/Education	☐ Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
☐ Psychoeducation	☐ Other: _____

Additional Information or Special Considerations

(e.g., safety planning, cultural factors, scheduling needs, etc.)

Referral Authorization

By submitting this referral, I affirm that the parent/guardian is aware of and consents to this referral for services.

Referring Staff Signature: _____
Date: _____

Please send completed form to:
Heather Irvin
Attn: Counseling Intake
Email: heather@treehousethomasville.org
Fax: 229-236-5441
Phone: 229-421-5032