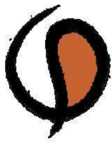

A S I A N **H U M A N** S E R V I C E S

Counseling Referral Form

Date:___________________ School: ____________________

Student Name: ______________________ Date of Birth: ____________

Parents' Language: _____________________ Insurance: Medicaid(MCO)__ HMO/PPO__

Classroom Teacher: _________________________ Grade: _______ Room #:_________

Reason for Referral *(brief description of behavioral, social or emotional problems)*:
Please use additional pages for description if needed

I give my consent for an Asian Human Services intake staff to consult with school regarding my child and to contact me for setting up counseling services.

Parents Name________________________ Parent Phone # ______________________

Signature of Parent ____________________ Date of Signature ___________________

Please circle ALL times that the student is available for sessions during the school day.

9:00am 9:30am 10:00am 10:30am 11:00am 11:30am 12:00pm 12:30pm 1:00pm 1:30pm 2:00pm 2:30pm 3:00pm 3:30pm

Please email referral form to AHSStudentReferrals@ahschicago.org [Attn: Child & Adolescent Mental Health. Give the original form to school counselor.

Asian Human Services, Inc.
4753 North Broadway, Suite 700, Chicago, Illinois 60640 tel: 773.293.8430 fax: 773.728.4751 website: www.ahschicago.org