



HEALTHY EDUCATED EMPLOYED

Counseling Referral Form

Date: _____ School: _____

Student Name: _____ Date of Birth: _____

Parents' Language: _____ Insurance: Medicaid (RIN) _____

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 AHSSStudentReferrals@ahschicago.org [Attn: Child & Adolescent Mental Health]. Give the original form to school counselor.