COUNSELING REFERRAL

School Year:_____________

Student's Name: ______________________________ DOB: ____________ ______________________________

Last/ First Placement

I recommend the above listed student receive the following services:

☐ Evaluation Requested

Reason for need:

____

____

☐ Counseling Services

Frequency: ______I______G ______minutes weekly

Effective from _____/_____/_____ to _____/_____/_____

Diagnostic statement/purpose of treatment:

____

____

____

____

____ ______________________ ____________________

Appropriate School Official (Print/Sign) Title Date

Note: A Referral for services must be completed for each IEP period. In addition, a new referral must be completed whenever reviews conducted during an IEP period result in a change in a service (either the addition of a service or a change in the frequency and/or duration of a service).