The Counseling Company by Rawhide

In-School Mental Health Program Referral Form

Student's Name: _____ Date of Birth: _____

Address: _____ Phone Numbers: _____

_____ _____

School Attending: _____ Gender: ☐ Male ☐ Female

Presenting Problems:

_____

_____

_____

_____

Goals for Treatment:

_____

_____

_____

_____

Payment Type:

☐ Private Insurance (Name of Ins. Co.) _____ ☐ Cash

☐ BadgerCare ☐ Other _____

Parent/Guardian Name: _____ Date of Birth: _____

Address (if different): Phone Numbers: _____

_____ _____

_____ Email Address: _____

Is the parent/legal guardian supportive of this referral? ☐ Yes ☐ No

Name of Foster Parent (if in foster care): _____

Address: _____ Phone Numbers: _____

_____ _____

_____ Email Address: _____

Referring Person:

Name: _____ Phone Numbers: _____

School or _____ _____

Agency: _____ Fax Number: _____

We must receive this completed form before we can discuss any information specific to this referral.

Parent/legal guardian must sign this form, giving us permission to contact them to set up an appointment for an assessment. A session will be scheduled after insurance coverage is verified or other payment options have been set up.

Please mail or fax this form to The Counseling Company, Attn: In-School Program, E7475 Rawhide Road, New London, WI 54961. Our fax number is **(920) 531-2686**. A follow-up is appreciated to verify the referral has been received. Please call us at **877-300-9101** or email **outpatient@rawhide.org**.

Thank you for your cooperation and thank you for this referral.

_____ _____

Parent/Guardian Signature Today's Date: