



# Recovery Unlimited, LLC

*There is a brighter day on the journey to recovery...*

[www.recoveryunlimitedllc.com](http://www.recoveryunlimitedllc.com)

## COUNSELING REFERRAL FORM

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ Currently In School  Yes  No School Name: \_\_\_\_\_

Officer: \_\_\_\_\_ Referred by: \_\_\_\_\_ Title: \_\_\_\_\_

- |                         |                                     |  |  |                                      |
|-------------------------|-------------------------------------|--|--|--------------------------------------|
| Reason(s) for Referral: | <input type="checkbox"/> Motivation | <input type="checkbox"/> Friendship problems | <input type="checkbox"/> Absences                | <input type="checkbox"/> Anger       |
|                         | <input type="checkbox"/> Bullying   | <input type="checkbox"/> Peer Relationships  | <input type="checkbox"/> Tardy                   | <input type="checkbox"/> Dishonest   |
|                         | <input type="checkbox"/> Swearing   | <input type="checkbox"/> Inattentive         | <input type="checkbox"/> Withdrawn               | <input type="checkbox"/> Grief       |
|                         | <input type="checkbox"/> Divorce    | <input type="checkbox"/> Hyperactive         | <input type="checkbox"/> Stealing                | <input type="checkbox"/> Fears       |
|                         | <input type="checkbox"/> Fighting   | <input type="checkbox"/> Social Skills       | <input type="checkbox"/> Depression              | <input type="checkbox"/> Sadness     |
|                         | <input type="checkbox"/> Worries    | <input type="checkbox"/> Personal Hygiene    | <input type="checkbox"/> Drug Use                | <input type="checkbox"/> Other _____ |
|                         | <input type="checkbox"/> Stressed   | <input type="checkbox"/> Lying               | <input type="checkbox"/> Destruction of Property |                                      |

Concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

Client's Strengths/Interests: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific Observable Behaviors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent / Guardian/Contact Person:  No  Yes Date: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Mother \_\_\_\_\_ Wk/Cell \_\_\_\_\_ Father \_\_\_\_\_ Wk/Cell \_\_\_\_\_

Outcome of Contact: \_\_\_\_\_  
\_\_\_\_\_

What other services is the client receiving (Out of school counseling, etc.): \_\_\_\_\_  
\_\_\_\_\_