MERCY SCHOOL-BASED THERAPUTIC PROGRAM REFERRAL FORM

Name of School: _____

Date of Referral: _____ Referred by: _____

Principal: _____ School Counselor: _____

First	Middle	Last
Date of Birth	Grade	Contact Number
Parent/Guardian		Date parent contacted about referral

Did parent agree to discuss referral with Mercy therapist?
Yes ( ) No ( )

Comments:

Does the student have an IEP?
Yes ( ) No ( )

If yes, please list file holder name here:

Does the student have a 504 plan?
Yes ( ) No ( )

If yes, please list 504 coordinator names here:

Is the child mandated to attend counseling through the courts or through DCS?
Yes ( ) No ( )

If yes, please put contact information here from the courts/DCS:

THIS SECTION IS ONLY TO BE COMPLETED BY MERCY COMMUNITY HEALTHCARE:	
Date Referral Received:	**Approved □ Yes □ No**
School-based Therapists:	
1st Contact: **Date:**	
2nd Contact: **Date:**	
3rd contact:	
Mercy Therapists:	