SUMMIT
COUNSELING GROUP

LAKE COUNTY SCHOOLS | Referral Form

Fax: 407.650.3073 | admin@mysummitcounseling.com

CLIENT

Client Name:	Gender: ☐ Male ☐ Female	Date of Birth:	Age:
Primary Caregiver:	Relation to Client:		
Email:	Best Contact #	Secondary Contact #	
Current Address:	City:	State:	Zip Code:
Primary Language: ☐ Englsih ☐ Spanish ☐ Other:_____	Grade:		

INSURANCE

Health Insurance:	Member Number:

SERVICE REQUESTED:

☐ Individual Counseling ☐ Family Counseling ☐ Occupational Therapy ☐ Speech/Language Therapy

☐ Psychosocial Rehabilitation ☐ Targeted Case Management ☐ Group Therapy

☐ Therapeutic Behavioral On-Site Services ☐ Other:_____

REASON FOR REFERRAL:

☐ Sadness ☐ Irritability ☐ Distracted ☐ Disruptive ☐ Aggressive Behaviors

☐ Constant Worry ☐ Lack of Energy ☐ Hyperactive ☐ Non-Compliance ☐ Speech Impairment

REFERRAL INFORMATION:

Referring Person:	Position:	
Campus Location:	Email:	Phone:

You must have a consensual release form signed by client to communicate with Summit Counseling Group.

_____ Signature

_____ Date