School-Based Therapy Referral Form

Wilmot Pupil Services Consortium:

Randall, Silver Lake, Twin Lakes, &
Wilmot Union High School Districts

Client/Student Name:	DOB/ Age:
School/District:	
SSN:	Phone #:
Street address:	City/State/Zip Code:
Referred By:	E-mail Address:
Parent/Guardian Name:	
Phone #:	Street address (if different):
City/State/Zip Code:	
Medical Assistance? Yes No	Type:
Commercial Insurance:	ID Number: Group #:

Reason for referral:

_____

_____

_____

_____

Expected Outcome:

_____

_____

_____

_____

Have parents been notified and agreed to services? _____Yes _____No

Best time of day to remove client/student from class: _____