Embrace mental health

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Pleasant Hill, CA 94523
embrace-mh.org
925.943.1794

Referral Form – ERMHS Counseling Services

Referral Date:	Student Name:		
Date of Birth:	Student Phone/Email:		
SpEd Eligibility:	Home Address:		
District:	Current School/Grade:		
IEP Team Members	**Name, Phone, Email**		
☐ Parent/Guardian/Caregiver			
☐ Parent/Guardian/Caregiver			
☐ District Contact			
☐ Case Manager			
☐ School-Based Counselor			
Reasons for Referral			
Desired Outcomes			
Services Requested (include service minutes/week + bank of hours/year)			
☐ Individual Counseling	_______ minutes/week	☐ In person	☐ Virtual (via Zoom)
☐ Parent Counseling	_______ minutes/week	☐ In person	☐ Virtual (via Zoom)
☐ Family Counseling	_______ minutes/week	☐ In person	☐ Virtual (via Zoom)
☐ Bank of Hours	_______ hours/year (for IEP attendance, report writing, and collaboration with IEP team)		
☐ Compensatory Services Needed	Service start date (as listed on IEP): _______________		

Please attach the following and indicate all that are available:

☐ SEIS access

☐ Current IEP with signed consent for services listed above

☐ Psychoeducational/Psychological/ERMHS assessment(s)

☐ EMBRACE intake packet (with *Authorization to Exchange Confidential Information*) signed by parent/guardian

Send To:
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