Embrace
mental health

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Referral Form – Intensive Behavioral Counseling (IBC)

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/ERMHS Counselor	
Reasons for Referral	
Desired Outcomes	
Service Requested	
Intensive Behavioral Counseling. Up to 30 hours per month of intensive wraparound support. Clinicians focus on providing behavioral coaching for caregivers and collaborating with the school/IEP team to improve a student's attendance and engagement at school.	
Has caregiver(s) consented to IBC? ☐ Yes ☐ No	
If yes, provide start date (as listed on IEP): _____ Caregiver(s) preference: ☐ In person ☐ Virtual (via Zoom)	
If no, provide date of next IEP meeting: _____ Would you like an EMBRACE representative to attend? ☐ Yes ☐ No	
Is student currently receiving counseling at school? ☐ Yes ☐ No	

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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