Counseling Services
Community Referral Form

Referral Location:	Referring Person:	
Date of Referral:	Phone:	Email:

Information on Youth

Youth's First and Last Name:	Date of Birth:	Age:
Caregiver's Name:	Relationship to Youth:	
Caregivers Primary Phone Number:	Caregiver's Secondary Phone Number:	
Caregiver's Email:		
Home Address/City/Zip		

Services Requested

☐Youth Counseling	☐ Family Counseling	☐Youth Group Counseling	☐Family Group Counseling

Reason for Referral:____

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*****Please notify caregiver that a Counselor will be contacting them to set up an appointment to register for services*****

Counselor: Jamie Taylor, MS
Counselor jtaylor@connectionsnonprofit.org

Supervisor: Lauren Richter, LPC-S
lrichter@connectionsnonprofit.org