Referral for On-Site Counseling at South Adams Schools

Martha Goller, MS, LMHC, NBCC
mgoller@southadams.k12.in.us
Phone: 260-589-3131

Date: _____

Person making referral: _____

Student name: _____

Age:_____ Grade:_____

Teacher:_____

Parent/Guardian Name _____

Contact number:_____

Reason for Referral:_____

_____

_____

_____

Parents give permission for their child/children to receive counseling services at SA. They understand that services are free and their child/children will meet with counselor during the school day, once a week or once every other week, for 30-50 minutes. Parent(parents) give permission for counselor to call and schedule a parent meeting with them at the school to sign appropriate paperwork to enroll their child (children)in counseling: _____ (initial)