Intake Scheduled Date: _____

Time of Intake: _____

Location: _____

Therapist: _____

COPE Referral Form

Clinic for Outreach and Personal Enrichment

Referral Form

Client Name: _____ Age:_____ Grade: _____

Guardian Name (if applicable):_____

Phone: (H) _____ (W)_____ (C)_____

Leave Message? Yes ☐ No ☐

Client's Email:_____ Guardians's Email:_____

Name of School/After school Program: _____

Referring Professional (if applicable): _____

Tell us how you heard about COPE: _____

Reason client may be in need of counseling:_____

_____

_____

_____

☐ Advised client of clinic policy: **Session may include a supervisor for training purposes. Counselors are supervised and the session may or may not be videotaped.**

We do not provide any information or verification of services for court proceedings of any kind as outlined in our contract for therapy. Tapes of sessions are for training only and are not provided to parent(s)/guardian.

REFERRING PROFESSIONAL'S STATEMENT OF RESPONSBILITY:

By endorsing this box, I am affirming that I have contacted the parent/guardian to inform them that they will be receiving information from the University of Mississippi Counselor Education program. ☐