Referral Form – Advent Group Ministries

Date of Referral:	
Student Name (Last Name, First Name):	
Student DOB:	
Student Phone #:	
Parent/Guardian Name and Contact #:	
Have Parents/ Guardian been notified about this referral? ☐YES ☐NO	
Do Parents/ Guardian speak English? ☐YES ☐NO - Language spoken:	
IEP/ 504 Plan (indicate type):	☐YES ☐NO If YES: Type of Plan:
Referrer Name & Telephone #:	
Relationship of Referrer with Student:	
School Counselor Name & Telephone#:	
Reason for referral:	
Student' strengths/ positive attributes: (Use page on the back if needed)	
PLEASE INCLUDE a copy of Student's Facesheet (School), and current class schedule	

Referrals can be sent via any of the following:

A. Via the Secured-Email Portal (TigerConnect).

a. 1st time users, please email CTEMPLE@adventgm.org (without any student information) to request an invitation.

B. Fax: Advent Group Ministries – Outpatient, FAX# 408-281-2658

- DO NOT send referral via email unless email system is secured -

This document may contain confidential and privileged material for the sole use of the intended recipient(s). Any review, use, distribution or disclosure by others is strictly prohibited. If you are not the intended recipient (or authorized to receive for the recipient), please contact Advent Group Ministries (408)281-0708. Any confidentiality or privilege is not waived or lost if this document has been sent to you by mistake.

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