PRIORITY: ___ Low (schedule when available) ___ High (schedule as soon as possible) ____ Emergency (see now)

CONFIDENTIAL SCHOOL COUNSELOR REFERRAL FORM

Date Received _____

Student's Name _____ Grade _____

Parent/Guardian Name _____ Phone # _____

Referred by: Teacher ____ Parent ____ Self ____ Other ____

Student lives with: _____

Reason(s) for Referral- Problems/Concerns related to: (Please check all that apply.)

[ ] Dramatic change in behavior
[ ] Worries
[ ] Daydream/fantasizes
[ ] Grief
[ ] Fears
[ ] Sadness
[ ] Always tired
[ ] Motivation
[ ] Inattentive
[ ] Withdrawn
[ ] Cries easily for age
[ ] Self-image/confidence
[ ] Non-touchable/pulls away
[ ] Nervous/anxious

[ ] Perfectionist
[ ] Aggression/Anger
[ ] Swearing
[ ] Fighting
[ ] Lying
[ ] Bullying
[ ] Disrespectful
[ ] Defiant
[ ] Hurts self
[ ] Impulsive
[ ] Over Active
[ ] Easily distracted
[ ] Chews (paper/clothes/hair)
[ ] Makes Odd Sounds

[ ] Stealing
[ ] Destruction of Property
[ ] Sexual Acting Out
[ ] Peer Relationships
[ ] Social Skills
[ ] Personal Hygiene
[ ] Family Concerns
[ ] Academics
[ ] Absence
[ ] Tardy
[ ] Work habits/organization
[ ] Completion of Assignments/Homework
[ ] Drop out risk (H.S.)
[ ] Other_____

Clarify Referral Problem / History:

_____
_____
_____
_____

ACTIONS taken by the person referring this student, if applicable: (Please attach copies of any interventions attempted)

_____
_____

Have you contacted parent/guardian about your concern? Y/N Date: Explain below the outcome of parent contact:

_____
_____

What other services is student receiving (out of school counseling, etc.)?

_____
_____

Signature of Person Making Referral _____ Date _____