CONFIDENTIAL SCHOOL COUNSELOR REFERRAL FORM

Student's Name ____ Grade ___________________

Parent/Guardian Name ____

Home Ph. (____)___________________

Work Ph. (____)______________ Cell Ph. _______________

Referred by: ___ Teacher ___ Parent ___ Self ___ Other

DOB ________________ DATE:__________

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

[ ] Academics

[ ] Absences

[ ] Daydream/fantasizes

[ ] Grief

[ ] Fears

[ ] Sadness

[ ] Always tired

[ ] Motivation

[ ] Inattentive

[ ] Withdrawn

[ ] Self image/confidence

[ ] Non-touchable/pulls away

[ ] Perfectionist

[ ] Nervous/anxious

[ ] Aggression/Anger

[ ] Swearing

[ ] Fighting

[ ] Lying

[ ] Bullying

[ ] Disrespectful

[ ] Defiant

[ ] Hurts self

[ ] [ ] Peer Relationships

[ ] Easily distracted

[ ] Stealing

[ ] Destruction of Property

[ ] Personal Hygiene

[ ] Family Concerns

[ ] behavior change

[ ] Worries

[ ] Wk habits/organization

[ ] Completion of Assignments/Homework

[ ] Social Skills

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 of Referral

______________________________ ______________________

PRIORITY LEVEL:

___ Low (schedule when available)

___ High (schedule as soon as possible)

____ Emergency (see now)