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

CONFIDENTIAL SCHOOL COUNSELOR REFERRAL FORM

Date Received _____

Student's Name: _____Teacher Name:_____Grade _____

Parent/Guardian Name_____ Phone: (___)_____

Email_____Referred by: ____Teacher ____Parent

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

[ ]Dramatic change in behavior
[ ]Worries
[ ]Daydream
[ ]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[ ]Withdrawn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
[ ]Teasing/Bullying
[ ]Disrespectful
[ ]Defiant
[ ]Hurts self
[ ]Impulsive
[ ]Over active
[ ]Easily distracted

[ ]Chews (paper/clothes/hair)
[ ]Makes Odd Sounds
[ ]Stealing
[ ]Destruction of Property
[ ]Anxiety/Separation Issues
[ ]Peer Relationships
[ ]Social Skills
[ ]Personal Hygiene
[ ]Family Concerns
[ ]Academics
[ ]Absences
[ ]Work Habits/Completion
[ ]Other

Clarify Referral Problem/History:

_____

_____

_____

ACTIONS taken by the person referring this student, if applicable:

_____

_____

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

_____

_____

What other services is the student receiving? (Out of school counseling, academic support, etc)

_____

Additional comments:

_____

_____