CONFIDENTIAL SCHOOL COUNSELOR REFERRAL FORM

Date Received _____

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

Student's Name _____ Grade & HmRm Teacher_____

Parent/Guardian Name _____
Student Lives with: _____

Referred by: ___ Teacher ___ Parent ___ Self ___ Other_____

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

[ ]Dramatic change in behavior	[ ] Self image/confidence	[ ] Impulsive
[ ] Worries	[ ] Nervous/anxious	[ ] Easily distracted
[ ] Daydream/fantasizes	[ ] Perfectionist	[ ] Academics
[ ] Grief	[ ] Aggression/Anger	[ ] Organization
[ ] Fears	[ ] Lying	[ ] Absences/ Tardy
[ ] Sadness	[ ] Bullying	[ ] Personal Hygiene
[ ]Relationships	[ ] Social Skills	[ ] Withdrawn
[ ]Family Concerns	[ ] Disrespectful	
[ ] Motivation	[ ] Defiant	
[ ] Inattentive	[ ] Completion of Assignments/Homework	

[ ] 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 and informed them of referral to counseling? Y/N Date: _____ Explain below the outcome of parent contact:

_____
_____

Best time(s) for student to pull out for counseling resources:

1_____
2_____
3_____

_____ _____

Signature of Person Making Referral Date of Referral Date