**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 & HmRm Teacher_____
First Last

Parent/Guardian Name _____ Home Ph. (____)_____

Work Ph. (____)_____ Cell Ph. _____ Referred by: ___ Teacher ___ Parent
___ Self ___ Other

DOB _____ 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[ ] Withdrawn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
[ ] Absences
[ ] Tardy
[ ] Wk 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 (Centerstone, out of school counseling, etc.)?

_____
_____

_____ _____
***Signature of Person Making Referral*** ***Date of Referral***

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

**Below is for the School Counseling office use only:**

Initial date seen by Counselor:_____ Counselor: _____

Best time to counsel with student: _____

Follow-up session Date: _____

Outcome: _____

Follow-up session Date: _____

Outcome: _____

Follow-up session Date: _____

Outcome: _____

Follow-up session Date: _____

Outcome: _____

Follow-up session Date: _____

Outcome: _____