**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[ ] Withdrawn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***

Rev 2011

**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: ____________________________________________________

Rev 2011