



SCHOOL COUNSELING REFERRAL FORM FOR PARENTS

Date _____ Student's name _____

Grade _____ School _____ Teacher _____

Referred by (your name) _____

Reason(s) for referral:

- | | | | |
|-------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> Motivation | <input type="checkbox"/> Friendship problems | <input type="checkbox"/> Absences | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Peer Relationships | <input type="checkbox"/> Tardy | <input type="checkbox"/> Dishonest |
| <input type="checkbox"/> Swearing | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Stealing | <input type="checkbox"/> Fears |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Social Skills | <input type="checkbox"/> Depression | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Worries | <input type="checkbox"/> Personal Hygiene | <input type="checkbox"/> Perfectionist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stressed | <input type="checkbox"/> Lying | <input type="checkbox"/> Destruction of Property | |

Concerns

Interventions tried _____

Have you contacted teacher about your concern? (date) _____

Explain _____

What other services is student receiving (out of school counseling, etc.)

The best way to reach you (include your contact information)

*Below is filled by the counseling department

Date seen by Counselor _____ Follow-up sessions _____

DOB _____ Student lives with _____