School Counseling Referral Form

Date_____

Age_____ Grade_____ Teacher_____

Students Name_____ DOB_____

Address_____

Home Phone_____ Student lives with_____

Contact Info_____

Is the student receiving special services yes no

Has the issue been discussed with parents/guardian yes no

Comments_____

Do we have permission from the parents to see the child yes no

Comments_____

Reason for referral- Check all that apply

Academic

Attendance	Study Skills
Underachievement	Organization
Homework	Other_____

Personal/Social

Aggression	Stealing	Personal hygiene
Dramatic Change in behavior	Sexual	Lying
Bullying – Victim or Bully	Peer Relationships	Impulsive
Self-injury	Social Skills	Always tired
Daydreaming	Family Concerns	Worried
Anger management	Sadness	Scared
Fighting	Self- image	Defiant
Hyperactive	Inattentive	Disruptive
Withdrawn	Nervous	Motivation

Best time to see the student _____or_____