Counseling Referral Form

STUDENT'S NAME: _____ DATE: _____
TEACHER: _____
PERSON MAKING THE REFERRAL: _____

MOODS/BEHAVIORS

_____ Anxious/worried
_____Depressed/unhappy
_____Eating disorder/body image issues
_____Hyperactive/inattentive
_____Shy/withdrawn
_____Low self-esteem
_____Aggressive behaviors
_____Stealing
_____Other: _____

SCHOOL CONCERNS

_____Homework not turned in/complete
_____Low test/assignment grades
_____Poor classroom performance
_____Sleeping in class/always tired
_____Sudden change in grades
_____Frequently tardy or absent
_____New student
_____Other: _____

RELATIONSHIPS

_____Bullying
_____Difficulty making friends
_____Poor social skills
_____Problems with friends
_____Boy/girl friend issues
_____Other: _____

HOME CONCERNS

_____Fighting with family members
_____Illness/death in the family
_____Parents divorced/separated
_____Suspected abuse
_____Suspected substance abuse
_____Other: _____

Comments: _____
_____
_____

Describe Student/Peer Relations: _____
_____
_____

Results of Parent/Teacher Contact: _____
_____
_____

Interventions Tried: _____
_____
_____

Counselor Use Only:
Date Received _____ Date Seen _____

Further Consult: No ____ Yes ____ Parent ____ Teacher____