Date Received ________

CONFIDENTIAL SCHOOL COUNSELING REFERRAL FORM: PARENT

Child's Name ______________________________ Teacher _______________ Grade_________

Parent/Guardian Name ________________________ Parent/Guardian Phone (___)______________

Student lives with: ____

Have you discussed your concerns with the teacher? Y/N Date: ____________

Outcome of teacher contact: ____

Reason(s) for Referral (check all that apply):

[ ] Major changes in behavior	[ ] Excessive worrying/anxiety	[ ] Grief/death
[ ] Sadness/Depressive behaviors	[ ] Withdrawn	[ ] Excessive crying
[ ] Self-image/confidence	[ ] Aggression/fighting	[ ] Bullying
[ ] Hyperactivity/Impulsivity	[ ] School refusal	[ ] Peer relationships
[ ] Social skills	[ ] Family concerns	[ ] Other ______________

Please provide a brief description of your reason for referral.

____

____

____

____

What actions have been attempted to support your child with this concern(s)?

____

____

____

Please provide additional information that you would like me to know.

____

____

____

____

Name of person completing referral: _______________________ Date: ________