Referral for Counseling Services

FOR DISTRICT OFFICE USE ONLY

Called: _____
Left Message:_____
_____

Date of Referral:_____

Does Student Receive: ❑Speech ❑RSP ❑SDC ❑Have a 504 Plan

Your Name_____ Position:_____

Student:_____ DOB:_____ Gender:_____

Grade:_____ Age:_____ School:_____ Room #_____

Parents Name:_____ Phone:_____ Work:_____

Address:_____ City:_____ Zip:_____

Is this a parent request for referral? Yes_____ No_____

Have you informed the parent that you will be referring this student? Yes_____ No_____

Check the type of problem behavior:

Academic	Social		Other
___Organization	___Aggression	___Frustration Tolerance	___Divorce
___Completion of Work	___Cooperation/Compliance	___Anger/Fear	___Death
___Attendance	___Withdrawal	___Bizarre	___Health
	___Disruptions	___Shy/Timid	___Risk Assessment
	___Off-Task	___Mood Swings	
	___Negativity	___Self Esteem	

Best **time** to meet with student: _____Classroom _____Recess _____Cafeteria _____Daycare _____ P.E.
(please specify time/hour as 9:00 am, 12:00 pm, etc.)

Specific and observable description of the problem:_____
_____
_____
_____

Medical diagnosis that might affect above:_____
_____
_____

Previous Remediation Attempts (If Any):_____
_____
_____
_____
_____

Please complete form and place in Counselor's box at your school.

Revised: 8/20/08 tc

**See Reverse Side for Response*

To Be Completed by District Counselor

Person Contacted: ( )Student ( )Mother ( )Father ( )Doctor ( )Agency

Date Contacted:_____

Met During: ( )Classroom ( )Recess ( )Cafeteria ( )Daycare ( )P.E.

Report:_____

Completed by:_____ Date:_____

CC: Carrie Jager, District Office
CC: Principal