PRIORITY: Low (schedule when	n available) <b>High</b> (so	chedule as soon as pos	sible)	Emergency (see now)	
co	ONFIDENTIAL SCHOOL C	OUNSELOR REFER	RAL FORM	Date Received	
Student's Name		Grade & HmRm Teacher			
First	Last	<del></del>			
Parent/Guardian Name			Home Ph. (_	)	
Work Ph. ()	Cell Ph	Referred by:	Teacher Self	Parent Other	
DOB Stud	ent lives with:				
Reason(s) for Referral- Probler  [] Dramatic change in behavior [] Worries [] Daydream/fantasizes [] Grief [] Fears [] Sadness [] Always tired [] Motivation [] Inattentive [] Withdrawn [] Cries easily for age [] Self image/confidence [] Non-touchable/pulls away  Clarify Referral Problem / History	[] Nervous/anxious [] Perfectionist [] Aggression/Anger [] Swearing [] Fighting [] Lying [] Bullying [] Disrespectful [] Defiant [] Hurts self [] Impulsive [] Over Active [] Easily distracted	•	othes/hair) nds roperty ut ps	[] Academics [] Absences [] Tardy [] Wk habits/organization [] Completion of Assignments/Homework []Drop out risk (H.S.) [] Other	
ACTIONS taken by the person ref	erring this student, if appli	i <b>cable:</b> (Please attach copi	ies of any interve	entions attempted)	
Have you contacted parent/guare Explain below the outcome of pa	•	Y/N Date:			
What other services is student re	ceiving (Centerstone, out	of school counseling	, etc.)?		

Date of Referral

Signature of Person Making Referral

PRIORITY: Low (schedule when available)	_ <b>High</b> (schedule as soon as possi	ble) Emergency (see now)			
Below is for the School Counseling office use only:					
Initial date seen by Counselor:	Counselor:				
Best time to counsel with student:					
Follow-up session Date:					
Outcome:					
Follow-up session Date:					
Outcome:					
Follow-up session Date:					
Outcome:					
Follow-up session Date:					
Outcome:					
Follow-up session Date:					
Outcome:					