

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):

- | | | |
|---|---|---|
| <input type="checkbox"/> Major changes in behavior | <input type="checkbox"/> Excessive worrying/anxiety | <input type="checkbox"/> Grief/death |
| <input type="checkbox"/> Sadness/Depressive behaviors | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Excessive crying |
| <input type="checkbox"/> Self-image/confidence | <input type="checkbox"/> Aggression/fighting | <input type="checkbox"/> Bullying |
| <input type="checkbox"/> Hyperactivity/Impulsivity | <input type="checkbox"/> School refusal | <input type="checkbox"/> Peer relationships |
| <input type="checkbox"/> Social skills | <input type="checkbox"/> Family concerns | <input type="checkbox"/> 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: _____