Counseling Referral Form

Student's Name:_____ **Grade:**_____ **Date:**_____

Referred by:_____ Teacher:☐ Parent:☐

Contact Information: Phone:_____ **Email**: org_____

Emergency? Yes☐ No☐ **Contacted Parent**? Yes☐ No☐

Reasons for Referral:

☐ Anger/Aggressive/Destructive
☐ Allegations of Neglect/Abuse
☐ Self Esteem
☐ Excessive Tardies/Absences
☐ Social Skills
☐ Disruptive/Disrespectful Behaviors
☐ Inappropriate Conduct
☐ Speaks of Self Harm
☐ Family Crisis (Divorce, Financial Hardship, Homeless, etc.)
☐ Academically Overwhelmed/Distracted/Stressed, Etc.
☐ Suspicion of Substance Abuse (Drug/Alcohol, etc.)

Comments (Please include any interventions, accommodations, or special services in place for the student prior to referral).

Teacher/Team Conference with Student☐ Parent Contact☐ Admin Referral☐ Other☐

_____

_____

Date seen:_____

Action(s) taken by counselor: Individual Counseling ____ Parent Contact_____

Social Work Referral_____ Consult with Teacher and Student's Progress will be monitored____

Group Counseling Recommended___ Meet with Student as Needed (check-in) _____

A Parent/Teacher/Counselor Conference Recommended_____

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DeKalb County School District