

Confidential School Counseling Referral Form

Student Name: _____ Date: _____

Referring Teacher: _____

Reason for Referral:

- | | |
|--|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Dramatic Change in Behavior | <input type="checkbox"/> Always tired |
| <input type="checkbox"/> Bullying – Victim | <input type="checkbox"/> Worried |
| <input type="checkbox"/> Bullying – Bully | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Self-Injury (i.e. cutting) | <input type="checkbox"/> Scared |
| <input type="checkbox"/> Daydreams/Fantasizes | <input type="checkbox"/> Defiant |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Inattentive |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Disruptive |
| <input type="checkbox"/> Sexual Acting Out | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Peer Relationships | <input type="checkbox"/> Nervous/Anxious |
| <input type="checkbox"/> Social Skills | <input type="checkbox"/> Motivation |
| <input type="checkbox"/> Family Concerns | <input type="checkbox"/> Academics |
| <input type="checkbox"/> Cries Easily/Often for Age | <input type="checkbox"/> Study Skills |
| <input type="checkbox"/> Self-Image/Self-Confidence | <input type="checkbox"/> Homework Completion |
| <input type="checkbox"/> Personal Hygiene | <input type="checkbox"/> Organization Skills |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Other |
| <input type="checkbox"/> Grief and Loss | |

Explanation:

Best time to pull the child from the classroom:

1st choice: _____

2nd choice: _____

Thank you for your referral! ☺