SCHOOL BASED THERAPY REFERRAL FORM

Student's Name _____School Counselor_____

Referred By _____Date_____

Parent/Guardian_____
Contact Information_____

Reason(s) for referral: (circle all that apply)

ACADEMIC	EMOTIONAL	SOCIAL	FAMILY
• Perfectionism • Attendance • Low motivation • Inattentive • Quality of work • Organization skills • Disrupts others' learning • Frequently leaves class • Other:	• Anxious/worried • Depressed/unhappy • Shy/withdrawn • Anger/hostility • Mood swings • Self-esteem • Other:	• Flagged on screener • Peer relationships • Bullying • Inappropriate language • Sexual acting out • Attention seeking • Makes excuses/blames others • Fighting • Lying • Stealing • Other:	• Separation/Divorce • Illness/Death/Loss • Recent change in address • Exposure to violence • Fighting with family members • DHHS involvement • Clinical Therapy • Changes in home environment (newborn, extended family, etc.) • Other:

Clarify problem/history:

_____
_____
_____
_____

Date(s) of P/G contact by school counselor:

_____

Parent/Guardian thoughts/suggestions about the concern:

_____
_____
_____

Have you mentioned School Counseling Services to parents? ☐ Yes ☐ No

How long have you had this concern? ☐ 2-3 weeks ☐ 1-2 month ☐ 3-6 months ☐ 6 months or more

When does this concern occur? ☐ Daily ☐ In the AM ☐ In the PM

Please rate the severity of the referral: Circle on a scale from 1-10 (1 – Less Serious; 10 – Very Serious):

1 2 3 4 5 6 7 8 9 10

Guidance Counselors rating of students level of functioning (1 - severe behaviors e.g. hurting self/others 10 – age appropriate e.g. maintains focus):

1 2 3 4 5 6 7 8 9 10

Teachers rating of student level of functioning (1 - severe behaviors e.g. hurting self/others 10 – age appropriate e.g. maintains focus):

1 2 3 4 5 6 7 8 9 10

ACTIONS taken by the person referring this student: (Please attach copies of attempted interventions)

_____
_____
_____
_____

What goal do you want this student to achieve?

_____
_____
_____

AREA BELOW FOR COUNSELOR USE ONLY:

Initial date met with student_____ Follow up scheduled Yes_____No____ Follow up date/time_____

Parent Contacted Yes ____ No _____

Date_____Outcome_____

Teacher contacted/updated (if involved) Yes ___ No ___ Date_____

Best time to meet with parents:_____

Best times to meet with student:

_____

Support Plans: