COUNSELING REFERRAL FORM

If this is an immediate threat that may result in a student possibly harming themselves or another student please call an administrator immediately. Please complete all questions with specific details.

Student Name: ____ Grade: _________ Date: ________________

Teacher/Administrator/Parent making referral: ____

School Site ____

Student must be seen today

Student can be seen in the next 2 or 3 school days

This student has an IEP

Reason(s) for referral:

Behavioral concern(s) observed:

Relevant history:

Family background:

Intervention(s) that have been tried and their result(s):

Student’s strengths and interests:

To the best of your knowledge this concern has existed: _______________# of weeks.

Approved by: ____ Date: _______________________
Director of Special Services

TO BE FILLED OUT BY SCHOOL PSYCHOLOGIST

Action/Plan:

Student was screened on ______________, date Principal advised on ________________, date

Parent/guardian was contacted, and “Counseling Consent Form” sent home.

Date sent home. _______________

Meeting was scheduled: _______________

Student will be counseled after permission is granted by parent.

Student referred for the following resource(s):

School Psychologist Signature ____ Date ____________________