

School Counseling Referral Form

Student: _____ Date _____

Grade _____ Teacher _____

Reason for referral (check all that apply)

Academic:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Study Skills |
| <input type="checkbox"/> Underachievement | <input type="checkbox"/> Organization |
| <input type="checkbox"/> Homework | <input type="checkbox"/> Goal Setting |
| <input type="checkbox"/> Other _____ | |

Personal/Social:

- | | |
|--|--|
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Adjustment |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Family Conflict |
| <input type="checkbox"/> Social Skills/Friends | <input type="checkbox"/> Health (family or self) |
| <input type="checkbox"/> Negative Attitude | <input type="checkbox"/> Grief (Loss/Death) |
| <input type="checkbox"/> Withdrawn/Shy | <input type="checkbox"/> Uncooperative/ Defiant |
| <input type="checkbox"/> Honesty | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Self-Esteem | <input type="checkbox"/> Theft/ Vandalism |
| <input type="checkbox"/> Personal Hygiene | |
| <input type="checkbox"/> Other _____ | |

Comments: _____

Best time to take student (Tuesday, Thursday, and Friday)

Time 1: _____ Time 2: _____ Time 3: _____

◆◆◆ Please reach out to parent so that they know you are making a referral ◆◆◆