School Counseling Referral Form
Parent Form

Child's Name: _____Grade: _____

Teacher: _____

Parent/Guardian Name:_____

Phone: _____ E-mail: _____

Reason(s) for referral:

___Anger	**____Peer relationships**	**____Dishonest/Lying**
___Sadness	**____Bullying**	**____Withdrawn**
___Fears	**____Social skills**	**____Time management**
___Worries/anxiety	**___Inattentive/Focus**	**____Organization**
___Stressed	**____Impulsive**	**____Divorce**
___Fighting	**____Destruction of Property**	**____Grief**
___Friendship problems	**____Stealing**	**____Other_____**

2. Have parent and teachers discussed concern? What was the outcome?

_____

_____

3. Possible issues or circumstances contributing to the referral:

_____

_____

_____

_____

4. What strategies/techniques have you tried with your child and what were the results?

_____

_____

_____

_____

5. What other services is student receiving?_____

_____

*This is a referral only-a parent/guardian consent form must be completed to receive counseling services.