Counseling Referral Form

Student Name ______________________________ Date ______________

Homeroom Teacher _________________________ Person Referring ________________

Reason for Referral

- ○ Aggression
- ○ Bullying-Victim
- ○ Bullying-Bully
- ○ Self-Injury
- ○ Anger Management
- ○ Fighting
- ○ Peer Relationships
- ○ Social Skills
- ○ Family Concerns
- ○ Self-Image/Self-Confidence
- ○ Personal Hygiene
- ○ Lying
- ○ Grief and Loss
- ○ Impulsive
- ○ Always tired
- ○ Worried
- ○ Sadness
- ○ Scared
- ○ Defiant
- ○ Hyperactive
- ○ Inattentive
- ○ Disruptive
- ○ Withdrawn
- ○ Nervous/Anxious
- ○ Motivation
- ○ Other: ________________

Explanation/Background:

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Actions taken by the person referring this student, if applicable: (Please attach copies of any interventions attempted)

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Have you contacted parent/guardian about your concern? __Yes __No Date: ___________

Explain below the outcome of parent contact:

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Best time to pull the student from the classroom:

1st choice: ________________ 2nd choice: ________________

Signature _______________________________ Date ________________

Thank you for your referral! Please return form to Mrs. Wallace or Ms. Walkup's box ☺