

PRIORITY (select one): Moderate (schedule when available) High (schedule as soon as possible) Emergency (see now)

*****CONFIDENTIAL*****

SHHS SCHOOL COUNSELOR REFERRAL FORM

Name of Student: _____ Grade: _____

Personal Making Referral: (Please Print) _____

Reason(s) for referral: (please check all that apply.)

<input type="checkbox"/> Academics <input type="checkbox"/> Fails to complete classwork <input type="checkbox"/> Fails to complete homework <input type="checkbox"/> Work/ study habits <input type="checkbox"/> Frequently absent <input type="checkbox"/> Frequently tardy <input type="checkbox"/> Sudden change in attendance <input type="checkbox"/> Always tired/ sleeps in class <input type="checkbox"/> Lack of motivation <input type="checkbox"/> Deteriorating appearance <input type="checkbox"/> Personal hygiene <input type="checkbox"/> Inattentive <input type="checkbox"/> Easily distracted <input type="checkbox"/> Impulsive <input type="checkbox"/> Hyperactive <input type="checkbox"/> Disruptive	<input type="checkbox"/> Dramatic change in behavior <input type="checkbox"/> Grief <input type="checkbox"/> Sadness <input type="checkbox"/> Frequently cries <input type="checkbox"/> Family concerns <input type="checkbox"/> Recent divorce/ separation in family <input type="checkbox"/> Peer relationships <input type="checkbox"/> Lack of social skills <input type="checkbox"/> Sexual acting out <input type="checkbox"/> Recent breakup <input type="checkbox"/> Suspected drug/alcohol use <input type="checkbox"/> Withdrawn or depressed <input type="checkbox"/> Makes concerning statements <input type="checkbox"/> Often hungry/ looking for food <input type="checkbox"/> Habitually uses vulgar language <input type="checkbox"/> Defiant/ Disrespectful	<input type="checkbox"/> Nervousness/ Anxious <input type="checkbox"/> Often Daydreams/ fantasizes <input type="checkbox"/> Lying <input type="checkbox"/> Bullying <input type="checkbox"/> Appears fearful <input type="checkbox"/> Self-image/ Self confidence <input type="checkbox"/> Non-touchable/ pulls away <input type="checkbox"/> Self-harm concerns <input type="checkbox"/> Perfectionist <input type="checkbox"/> Stealing <input type="checkbox"/> Destruction of property <input type="checkbox"/> Chews (paper/ clothing/ hair) <input type="checkbox"/> Frequent visits to the bathroom <input type="checkbox"/> Frequent visits to the nurse <input type="checkbox"/> Anger/ Aggression <input type="checkbox"/> Fighting
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Other _____

Please elaborate about your concerns below, or would you prefer us to contact you instead? Yes

Have you contacted the parent/ guardian about your concerns? Y / N Date of contact: _____

If Y, outcome: _____

Have you contacted administration about your concerns? Y / N If so, who: _____

If Y, outcome: _____

Do you feel this student needs Tier II/ Tier III interventions? (Care and Support Team (CAST) Referral, School Social Work Referral / Behavior Plan/ Check-in Check-out/ Referral for Therapy, etc.) Y/ N

Signature of Person Making Referral

Date of Referral

Thank you for taking the time to bring this student to our attention!

****Please return this form to your student's counselor in a sealed envelope****

(Mrs. Johnson: Grades 9 & 10***Mrs. Zollinger: Grades 11 & 12)

Below is for the SHHS School Counseling Office use only:

Initial date seen by School Counselor: _____ Counselor: _____

Outcome: _____

Referrals made: _____

Follow up session date (if needed): _____

Outcome: _____

Referrals made: _____

Follow up session date (if needed): _____

Outcome: _____

Referrals made: _____

Follow up session date (if needed): _____

Outcome: _____

Referrals made: _____

Follow up session date (if needed): _____

Outcome: _____

Referrals made: _____

Follow up session date (if needed): _____

Outcome: _____

Referrals made: _____

Notes: