

COUNSELING DEPARTMENT STUDENT REFERRAL FORM
by TEACHERS, STAFF, PARENTS

Date of Request: _____

Student's name: _____ Grade: _____

Referring Teacher/Staff/Parent name: _____

Teacher Room #: _____ Parent Phone #: _____

CONCERN/PROBLEM:

Drugs/Alcohol _____ Disturbs Class _____ Defiant/Noncompliant _____ Harassing _____

Threatening _____ Arguing _____ Fighting _____ Cursing _____ Withdrawn _____

Depressed/Sad _____ Anxious _____ Isolated _____ Self-Injurious Behavior _____

Other _____

Explain: _____

Student's Strengths/Talents: _____

Interventions attempted, if any _____

Requested Intervention (*check all that apply*):

_____ Teacher/Staff/Parent consultation with Mr. Flesch

Best/preferred time _____

_____ Mr. Flesch follow up with student

_____ Other _____