

School Counselor Referral

Your Name: _____ Date _____

Student's Name: _____

PLEASE CHECK AS MANY OF THE FOLLOWING ITEMS WHICH APPLY

OBSERVED BEHAVIORS

- Academic problems
- Arguing with others
- Fighting
- Angry outbursts
- Having no friends
- Lying
- Refusing to eat
- Concerned about weight
- Destructive
- Cries easily—oversensitive
- Causing trouble for no reason
- Defiant
- Yelling, swearing, or screaming at others
- Can't seem to sit still, too much energy
- Hurting self (scratching, cutting, etc.)
- Talking or thinking about death
- Other: _____

SITUATIONS

- Change in custody
- Traumatic event
- Change in residence
- Financial problems
- Divorce
- Family/personal medical problem
- Death of a family member or close friend
- Family member or close friend in prison
- Drug or alcohol abuse in family
- Change in household composition

Extra comments:

May I tell the student who referred her? (circle one) Yes No