# Mental Health Counseling Referral Form

Student Name: _____DOB:_____Date: _____

Grade: _____Person Referring: _____

**Reason for Referral** – check all that apply

**Academic:**

___Attendance
___Study Skills
___Cheating
___Other _____
___Skill Deficiency
___Organization
___Academics
___Homework

**Personal/Social:**

___Aggression/anger
___Disrespectful
___Nervous/Anxious
___Health (Family or Student)
___Honesty
___Self-harm
___Fears
___Sexual Acting Out
___Sadness
___Gets out of seat constantly
___Elopement
___Drug use/ideation
___Other_____
___Bullying/Harassment
___Withdrawn/Shy
___Adjustment
___Grief
___Self-esteem
___Property Destruction
___Social Skills
___Low/Decreased Motivation
___Stealing
___Interrupts/blurts responses
___Cursing/Yelling/Screaming
___Peer Relationships
___Uncooperative/Defiance
___Family Conflict
___Homeless
___Personal Hygiene
___Dramatic Change in Behavior
___Impulsive
___Easily Distracted
___Inattentive
___History of Trauma
___Arson
___Suicidal Ideation
___Weapons

Duration of issues:_____

Have you discussed your concerns with the child's parent or guardian? ___Yes ___No

Does the child receive outpatient therapy services? If yes, please list provider. ___Yes ___No

Outpatient Therapist Name: _____ Phone: _____

Is there a release to speak to the outpatient therapist? ___Yes ___No

Does the child have an IEP? ___Yes ___No

If yes, who is the IEP case manager? _____

Additional Comments:

_____

_____

_____

_____

Parent phone and email:_____ Revised 4/20