

# Referral Form for Student Mental Health and Counseling Support

Student Name	Grade Level	Gender	Date Form Completed
Name of Person Making Referral		Contact # or Email for Person Making Referral	
Relationship to Student: <input type="checkbox"/> Teacher <input type="checkbox"/> School Staff <input type="checkbox"/> Friend/Family Member		Contact # or Email for Parent/Guardian	
		Do you want the student to know you made the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Has the student or family asked for:**

Information about services? <input type="checkbox"/> Yes <input type="checkbox"/> No	An appointment to initiate help? <input type="checkbox"/> Yes <input type="checkbox"/> No	Someone to contact them to offer help? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Please rate the urgency of this request by circling the appropriate number:**

Not Urgent		Moderately Urgent						Very Urgent	
1	2	3	4	5	6	7	8	9	10

**Please check area(s) of concern that are demonstrated on a consistent/frequent basis:**

**ACADEMIC**

<input type="checkbox"/> Grades falling significantly	<input type="checkbox"/> Does not complete homework	<input type="checkbox"/> Has difficulty with written language	<input type="checkbox"/> Difficulty with peers in classroom	<input type="checkbox"/> Easily distracted
<input type="checkbox"/> Skipping classes	<input type="checkbox"/> Has low reading skills	<input type="checkbox"/> Inverts/reverses numbers/letters	<input type="checkbox"/> Unable to follow directions	<input type="checkbox"/> Falling asleep in class
<input type="checkbox"/> Excessive tardiness	<input type="checkbox"/> Has difficulty with math skills	<input type="checkbox"/> Possible auditory/vision difficulties	<input type="checkbox"/> Inability to stay on task/complete assignments	<input type="checkbox"/> Requires frequent one-on-one attention
<input type="checkbox"/> Low motivation/effort				<input type="checkbox"/> Other:

**APPEARANCE**

<input type="checkbox"/> Appearance/hygiene neglected	<input type="checkbox"/> Bloodshot eyes	<input type="checkbox"/> Needle or burn marks	<input type="checkbox"/> Weight loss/gain (dramatic/sudden)	<input type="checkbox"/> Other:
	<input type="checkbox"/> Bruises			

**BEHAVIOR**

<input type="checkbox"/> Abusive language/profanity	<input type="checkbox"/> Cutting/scratching/hurting self	<input type="checkbox"/> Inappropriate displays of affection/clingy	<input type="checkbox"/> Preoccupied with death	<input type="checkbox"/> Threatening/intimidating remarks/bullying
<input type="checkbox"/> Alcohol/drug abuse (suspected or known)	<input type="checkbox"/> Destruction of property	<input type="checkbox"/> Irritable/angry/hostile	<input type="checkbox"/> Rejected by peers/picked on	<input type="checkbox"/> Worrying/nervousness
<input type="checkbox"/> Argumentative	<input type="checkbox"/> Disruptive	<input type="checkbox"/> Isolated/withdrawn	<input type="checkbox"/> Self-esteem problems	<input type="checkbox"/> Other:
<input type="checkbox"/> Attention seeking	<input type="checkbox"/> Eating problems (too much or too little)	<input type="checkbox"/> Lethargic/low energy	<input type="checkbox"/> Separation anxiety	
<input type="checkbox"/> Bizarre thoughts or behaviors (i.e., hearing voices, seeing things, eating inedible objects, rocking, head banging)	<input type="checkbox"/> Excessive or uncontrollable crying	<input type="checkbox"/> Negative peer influences	<input type="checkbox"/> Sexually assaultive toward others/vulgar	
	<input type="checkbox"/> Gang involvement	<input type="checkbox"/> Physically assaultive toward others/fighting	<input type="checkbox"/> Suffered sexual and/or physical assault	
		<input type="checkbox"/> Pregnant	<input type="checkbox"/> Talks about suicide	

**DIFFICULTY MAKING TRANSITIONS**

<input type="checkbox"/> New student having trouble with adjustment	<input type="checkbox"/> Trouble adjusting to new living situation
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**FAMILY/ENVIRONMENT**

<input type="checkbox"/> Homeless (no fixed address, living with others)	<input type="checkbox"/> Reports abuse (physical, sexual, emotional)	<input type="checkbox"/> Suffered recent loss (including parent divorce)
<input type="checkbox"/> Inadequate food source	<input type="checkbox"/> Speaks with anger about parents/family	<input type="checkbox"/> Other:

*By law, reports that may indicate abuse or neglect may have to be referred to the Child and Family Services Agency. See the mandated reporting protocol or consult with a member of the school-based mental health team for more information.*



**PLEASE RETURN COMPLETED FORMS TO YOUR SCHOOL MENTAL HEALTH COORDINATOR.**