

### Teacher Referral for Counseling Services

Student name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Teacher: \_\_\_\_\_

Reasons for referral (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Aggression                                       | <input type="checkbox"/> Self-image/Self-esteem |
| <input type="checkbox"/> Dramatic change in behavior                      | <input type="checkbox"/> Grief and loss         |
| <input type="checkbox"/> Bullying – target                                | <input type="checkbox"/> Always tired           |
| <input type="checkbox"/> Bullying – perpetrator                           | <input type="checkbox"/> Sadness                |
| <input type="checkbox"/> Self-Injury (cutting, biting, head-banging etc.) | <input type="checkbox"/> Worried/Scared         |
| <input type="checkbox"/> Daydreams/Fantasizes                             | <input type="checkbox"/> Defiant                |
| <input type="checkbox"/> Anger Management                                 | <input type="checkbox"/> Impulsive/Hyperactive  |
| <input type="checkbox"/> Physical fighting                                | <input type="checkbox"/> Inattentive/Distracted |
| <input type="checkbox"/> Stealing   | <input type="checkbox"/> Disruptive             |
| <input type="checkbox"/> Lying  | <input type="checkbox"/> Withdrawn              |
| <input type="checkbox"/> Sexualized behavior                              | <input type="checkbox"/> Anxious/Nervous        |
| <input type="checkbox"/> Difficulty in peer relationships                 | <input type="checkbox"/> Drastic mood shifts    |
| <input type="checkbox"/> Social skills                                    | <input type="checkbox"/> Lacks motivation       |
| <input type="checkbox"/> Family concerns                                  | <input type="checkbox"/> Work completion        |
| <input type="checkbox"/> Change in family dynamics                        | <input type="checkbox"/> Organizational skills  |
| <input type="checkbox"/> Cries easily/often for age                       | <input type="checkbox"/> Personal hygiene       |
| <input type="checkbox"/> Rigid/Inflexible                                 | <input type="checkbox"/> Suicidal ideation      |
| <input type="checkbox"/> Other  |   |

Explanation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are parents/guardians aware of your concerns?  YES  NO

When is a good time to pull the child from the classroom?

1<sup>st</sup> choice \_\_\_\_\_

2<sup>nd</sup> choice \_\_\_\_\_

*Thank you for your referral.  
Please place your completed form in the "Referrals" envelope in my mailbox.*