

Request for Counseling

Attn:

Referred By:

Date:

Students Name:

Age:

Grade:

Parent/Guardian Name:

Phone Number:

Medicaid #:

Consent to Refer Given by Parent/Guardian:

Date Consent Given:

**** IF CURRENT SUICIDAL IDEATION EXISTS, CONTACT COUNSELOR DIRECTLY ****

Current Concerns Regarding This Student:

Social Skills

Anxiety

Anger management

Divorce Issues

Self-esteem

Death of loved one

Depression

History of suicidal thoughts

Abuse/neglect

Self Harm

Family Issues

Conflicts with:

Behavioral Issues

ADHD

Other (provide details below)

List Strategies Implemented That Have Been Unsuccessful:

TIER ONE STRATEGIES

TIER TWO STRATEGIES

For Counselor's Use Only

Dates of Contact:

Assessment Scheduled:

Referral

If closed, give reason why: