

REFERRAL FOR COUNSELING SERVICES

CHILD'S PRIMARY LANGUAGE: _____

GUARDIAN'S PRIMARY LANGUAGE: _____

REFERRING PARTY INFO

DATE: _____ GRADE: _____ SPEC EDUCATION: YES NO

SCHOOL: _____ SCHOOL COUNSELOR: _____

ROOM #: _____ REFERRING PARTY'S EMAIL: _____

TEACHER: _____ Email address for others who should receive information regarding thsi referral : _____

PLEASE CONTACT PARENTS FIRST:
Have you informed the guardian that a mental health referral has been made? YES NO

REFERRED PARTY INFO

NAME: _____ SOCIAL SECURITY # _____

DOB: _____ GENDER: Male Female

ADDRESS: _____ ZIP: _____ PHONE#: _____

LEGAL GUARDIAN: _____ RELATION: _____

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DHS SOCIAL WORKER/ PROBATION OFFICER: _____

BRIEF DESCRIPTION OF PRESENTING PROBLEM: _____

SYMPTOMS, PLEASE CHECK ALL THAT APPLY

DEFIANCE: loses temper argues defiant angry resentful annoying spiteful hits

SERIOUS CONDCUT BEHAVIORS: cruel to animals/ people fights steals sexual misconduct deceitful runaway criminal behaviors gang affiliation drug abuse alcohol abuse homicidal ideation

ATTENTION PROBLEMS: inattention distractable forgetful hyperactive poor concentration fidgets inappropriate activity impulse blurts out interrupts

MOOD AND EMOTIONS: depressed hopeless helpless withdrawn cries irritable suicidal ideation isolates self sleep increase/decrease poor concentration appetite increase/ decrease

STRANGE BHEAVIORS: delusions hallucinations paranoia isolates self "lost in their own world"

AREAS FUNCTIONALLY IMPAIRED DUE TO SYMPTOMS, PLEASE CHECK ALL THAT APPLY

school/education social relationships home/family relationships physical health "lost in their own world"

DISPOSTION (FOR OFFICE USE ONLY)

REFERRING PARTY'S EMAIL: _____

ASSESSMENT DATE: _____ THERAPIST: _____ REFERRING PARTY INFORMED: _____