PRIORITY: _____ **Low** (schedule when available) ___ **High** (schedule as soon as possible) ____ **Emergency** (see now)

CONFIDENTIAL SCHOOL COUNSELOR/STUDENT SUPPORT COUNSELOR REFERRAL FORM

Date Received ________

Student's Name ______________________________ Grade ______________________
First Last

Parent/Guardian Name ______________________________ Contact Info: ______________________

Referred by: _______ Teacher/Teacher Asst. /Aide _______ Self _______ Other _______Parent

Student lives with: ____

Reason(s) for Referral- Problems/Concerns related to: (*Please check all that apply.*)

- ☐ Dramatic change in behavior
- ☐ Worries
- ☐ Daydream/fantasizes
- ☐ Grief
- ☐ Fears
- ☐ Sadness
- ☐ Always tired
- ☐ Motivation
- ☐ Inattentive
- ☐ Withdrawn
- ☐ Cries easily for age
- ☐ Self-image/confidence
- ☐ Non-touchable/pulls away
- ☐ Nervous/anxious
- ☐ Perfectionist
- ☐ Aggression/Anger
- ☐ Swearing
- ☐ Fighting
- ☐ Lying
- ☐ Bullying
- ☐ Disrespectful
- ☐ Hurts self
- ☐ Impulsive
- ☐ Over Active
- ☐ Easily distracted
- ☐ Chews(paper/clothes/hair)
- ☐ Makes Odd Sounds
- ☐ Stealing
- ☐ Destruction of Property
- ☐ Sexual Acting Out
- ☐ Peer Relationships/Social Skills
- ☐ Personal Hygiene
- ☐ Family Concerns
- ☐ Academics AbsencesTardy
- ☐ Work habits/organization
- ☐ Completion of Assignments/Home work
- ☐ Drop out risk (H.S.)
- ☐ Other__________

Clarify Referral Problem / History: (*Please attach paper if more space is needed*)

____

____

____

____

ACTIONS *taken by the person referring this student, if applicable: (Please attach copies of any interventions attempted)*

____

____

____

Does child receive any outside supports/counseling? If yes, please specify:______________________

______________________________ ______________________

Signature of Person Making Referral ***Date of Referral***

Complete this form and send to WCS via mail at PO Box 180, Willsboro, NY or via email to Chris Ford: chrisford@willsborocsd.org
The counseling department will review your submission and be in touch as soon as possible.

If your child is in need of immediate counseling support, reach out to Essex County Mental Health Services 7513 Court Street, Elizabethtown, NY or by phone at 518-873-3670.

After hours & weekends, call 1-888-854-3773.

10/2023

Below is for the School Counseling office use only:

Date Received: ________________

Assigned Counselor:

______ Sadie Trunck, School Psychologist

______ Chris Ford, School Counselor

______ Jennifer Leibeck, CSE Chair

______

Planned Intervention:

_____ Check-in

_____ Individual Session(s)

_____ Group Session(s)

_____ Other: _________________