

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.)

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 Withdrawn | 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

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.

Below is for the School Counseling office use only:

Date Received: _____

Assigned Counselor:

_____ Sadie Trunck, School Psychologist

_____ Chris Ford, School Counselor

_____ Jennifer Amorelli, Elementary School Counselor

Planned Intervention:

_____ Check-in

_____ Individual Session(s)

_____ Group Session(s)

_____ Other: _____