



Oak View School Counseling Referral Form

Student Name: _____ Referral Date: _____

Referred by (Name): _____

Gender: Male _____ Female _____ Age: _____ DOB: _____

Parent/Guardian: _____

Home Address: _____

Phone #: _____ Home or Cell (Circle one)

Was the parent/guardian informed? Yes _____ No _____ Date informed _____

❖ REASON FOR REFERRAL: (please check all that apply)

- Academics Behavior Emotional Management
Social Interactions Trauma Family Hardships
Depression Grief Environmental Hardships
Anxiety Poor Decision Making Other:

❖ Behavioral &/or medical history related to the concerns/challenges:

- 1.
2.
3.

❖ Previous classroom &/or family strategies/interventions to remedy current concerns/challenges:

- 1.
2.
3.

❖ Specific goals you would like to see this student work on:

- 1.
2.
3.

❖ Student strengths:

- 1.
2.
3.

PLEASE SEND REFERRALS TO: Sierra Blanco, sierra@180lodi.org