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: Kate Qualls – kqualls@myoakview.com