"STRIVE TO ENGAGE AND CHALLENGE EVERY STUDENTS' EDUCATION TODAY FOR TOMORROW"

GORE PUBLIC SCHOOLS

1200 North Highway 10
Gore, Ok. 74435

Counselor Referral form

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

CONFIDENTIAL SCHOOL COUNSELOR REFERRAL FORM Date Received _____

Student's Name _____ Grade:_____
Base room Teacher_____
Parent/Guardian Name _____
Cell Ph. _____ Work Ph. (____)_____
Student DOB _____ Student lives with: _____

Referring Party Information: Will be kept confidential.
Referred by: Teacher: ___ Parent: ___ Self: ___ Other:_____

Name and contact information of referring party:
Name: _____
Phone: (___)___ - _____ email address: _____

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

[ ]Dramatic change in behavior [ ] Worries [ ] Daydream/fantasizes
[ ] Grief [ ] Inattentive [ ] Withdrawn [ ] Cries easily for age
[ ] Self image/confidence [ ] Non-touchable/pulls away [ ] Nervous/anxious
[ ] Perfectionist [ ] Aggression/Anger [ ] Swearing
[ ] Fighting [ ] Lying [ ] Bullying [ ] Disrespectful [ ] Defiant

[ ] 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
[ ] Absences [ ] Tardy [ ] Wk habits/organization
[ ] Completion of Assignments/Homework [ ]Drop out risk (H.S.) [ ] Homeless
[ ] Neglected or Delinquent [ ] Other_____

Clarify Referral Problem / History:

_____
_____
_____
_____

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

_____
_____

Have you contacted parent/guardian about your concern? Y/N Date: _____
Explain below the outcome of parent contact:

_____
_____

What other services is student receiving (Centerstone, out of school counseling, etc.)?

_____
_____
_____ _____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Person Making Referral Date of Referral

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Below is for the School Counseling office use only:

Initial date seen by Counselor:_____ Counselor: _____

Best time to counsel with student: _____

Follow-up session Date: _____

Outcome: _____

Follow-up session Date: _____

Outcome: _____

Follow-up session Date: _____

Outcome: _____

Follow-up session Date: _____

Outcome: _____

Follow-up session Date: _____

Outcome: _____

OFFICE USE ONLY