

School Counselor Referral Form

Bloom-Carroll Intermediate School



Student: _____ Date: _____

Grade: _____ Teacher: _____

Reason for referral (check all that apply)

Academic:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Study Skills |
| <input type="checkbox"/> Test Taking | <input type="checkbox"/> Organization |
| <input type="checkbox"/> Time Management | <input type="checkbox"/> Goal Setting |
| <input type="checkbox"/> Other _____ | |

Personal/Social:

- | | |
|--|--|
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Adjustment |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Family Conflict |
| <input type="checkbox"/> Social Skills/Friends | <input type="checkbox"/> Health (family or self) |
| <input type="checkbox"/> Negative Attitude | <input type="checkbox"/> Grief (Loss/Death) |
| <input type="checkbox"/> Withdrawn/Shy | <input type="checkbox"/> Uncooperative/ Defiant |
| <input type="checkbox"/> Honesty | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Self-Esteem | <input type="checkbox"/> Theft/ Vandalism |
| <input type="checkbox"/> Personal Hygiene | |
| <input type="checkbox"/> Other _____ | |

Comments:

Are parents/guardians aware of your concerns? Yes Not Yet

Comments:

Best time to take student (Remember I am only here Mondays and Wednesdays)

Time 1: _____ Time 2: _____ Time 3: _____

***When completed, please place in "Referrals" folder in Miss Connor's mailbox ☺ ***