

## Form 4.1: Elementary School Counseling Referral Form

Please complete and return this confidential referral form to me. The form should be closed in a sealed envelope and placed in my office mailbox. Do not duplicate.

To: \_\_\_\_\_ School Counselor \_\_\_\_\_ Date \_\_\_\_\_

### Priority

Low (schedule when available); High (as soon as possible); Emergency (see now)

Student's name and grade \_\_\_\_\_

Referred by \_\_\_\_\_

Please check any behaviors of concern that you have observed:

- |   |  |
|---|--|
| <input type="checkbox"/> aggression                         | <input type="checkbox"/> academics                 |
| <input type="checkbox"/> dramatic change in behavior        | <input type="checkbox"/> homework completion       |
| <input type="checkbox"/> bullying—victim                    | <input type="checkbox"/> study skills              |
| <input type="checkbox"/> bullying—bully                     | <input type="checkbox"/> organizational skills     |
| <input type="checkbox"/> daydreams/fantasizes               | <input type="checkbox"/> impulsive                 |
| <input type="checkbox"/> poor peer relationships            | <input type="checkbox"/> always tired              |
| <input type="checkbox"/> poor social skills                 | <input type="checkbox"/> inattentive               |
| <input type="checkbox"/> family concerns (illness, divorce) | <input type="checkbox"/> disruptive                |
| <input type="checkbox"/> suspected abuse                    | <input type="checkbox"/> worried/anxious           |
| <input type="checkbox"/> cries easily/often for age         | <input type="checkbox"/> scared                    |
| <input type="checkbox"/> self-image/self-confidence         | <input type="checkbox"/> sadness                   |
| <input type="checkbox"/> personal hygiene                   | <input type="checkbox"/> withdrawn/shy             |
| <input type="checkbox"/> lying                              | <input type="checkbox"/> depressed                 |
| <input type="checkbox"/> stealing                           | <input type="checkbox"/> defiant                   |
| <input type="checkbox"/> grief and loss                     | <input type="checkbox"/> difficulty making friends |
| <input type="checkbox"/> other                              |  |

Explanation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Best time to pull child from class: 1st choice \_\_\_\_\_ 2nd choice \_\_\_\_\_

I recommend this child for individual counseling \_\_\_\_\_; small group counseling \_\_\_\_\_.

Thank you for taking the time to share this information with me.

## Form 4.2: Secondary School Counseling Referral Form

Please complete this confidential counseling referral form, place it in a sealed envelope, and place it in the mailbox of the counselor to whom you are making the referral. Do not duplicate.

Date referral received \_\_\_\_\_

Counselor's name \_\_\_\_\_

Student's name and grade \_\_\_\_\_

Referred by \_\_\_\_\_

### Priority:

Low (schedule when available)      High (as soon as possible)      Emergency (see now)

Have you had a discussion with the child's parent(s) regarding this referral? Yes or no

### Student's Present Functioning (as you perceive it)

|                           | <i>Excellent</i> | <i>Above average</i> | <i>Average</i> | <i>Below average</i> | <i>Poor</i> |
|---------------------------|------------------|----------------------|----------------|----------------------|-------------|
| Self-directed learner     |                  |                      |                |                      |             |
| Attention span            |                  |                      |                |                      |             |
| Quality of writing        |                  |                      |                |                      |             |
| Self-image                |                  |                      |                |                      |             |
| Attitude toward authority |                  |                      |                |                      |             |
| Peer relationships        |                  |                      |                |                      |             |
| Works well with others    |                  |                      |                |                      |             |
| Completes assignments     |                  |                      |                |                      |             |
| Follows classroom rules   |                  |                      |                |                      |             |

**Please check any behaviors of concern that you have observed or have knowledge of:**

academic

tardiness

absences

depression

anger/aggression

family issues (illness, divorce)

truancy

stress/anxiety

suicidal thoughts

health/hygiene

- |  |   |
|--|---|
| <input type="checkbox"/> peer relationships          | <input type="checkbox"/> student/teacher issues   |
| <input type="checkbox"/> boyfriend/girlfriend issues | <input type="checkbox"/> student/parent issues    |
| <input type="checkbox"/> dramatic change in behavior | <input type="checkbox"/> hurts/cuts self          |
| <input type="checkbox"/> sexuality issues            | <input type="checkbox"/> child neglect/abuse      |
| <input type="checkbox"/> dropout risk                | <input type="checkbox"/> work habits/organization |
| <input type="checkbox"/> grief/loss                  | <input type="checkbox"/> withdrawn                |
| <input type="checkbox"/> bullying—victim             | <input type="checkbox"/> substance abuse          |
| <input type="checkbox"/> bullying—bully              | <input type="checkbox"/> other                    |

Special skills, talents, or competencies this student has \_\_\_\_\_  
 \_\_\_\_\_

Reason for referral (based on your observations) \_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Position \_\_\_\_\_

## Form 4.3: Mental Status Checklist

### Appearance and Behavior

|                      | <i>Check if applies</i>         | <i>Circle</i>  | <i>Therapist's Comments</i>      |
|----------------------|---------------------------------|--|----------------------------------|
| 1. Posture           | Normal _____                    | Limp, rigid, ill at ease                                       | _____                            |
| 2. Gestures          | Normal _____                    | Agitated, tics, twitches                                       | _____                            |
| 3. Grooming          | Neat _____                      | Well groomed,<br>disheveled,<br>meticulous<br>Dirty, careless, | _____<br>_____<br>_____<br>_____ |
| 4. Dress             | Casual _____<br>Formal _____    | inappropriate,<br>seductive                                    | _____<br>_____                   |
| 5. Facial expression | Appropriate _____               | Poor eye contact,<br>dazed, staring                            | _____                            |
| 6. Speech            |                                 |  | _____                            |
| a. Pace              | Normal _____                    | Retarded, pressured,<br>blocking                               | _____<br>_____                   |
| b. Volume            | Normal _____                    | Soft, very loud,<br>monotone                                   | _____<br>_____                   |
| c. Form              | Logical _____<br>Rational _____ | Illogical, rambling,<br>incoherent, coherent                   | _____<br>_____                   |
| d. Clarity           | Normal _____                    | Garbled, slurred   | _____                            |
| e. Content           | Normal _____                    | Loose, associations,<br>rhyming, obscene                       | _____                            |

**Attention/Affect/Mood**

|              | <i>Check if applies</i>     | <i>Circle</i>   | <i>Therapist's Comments</i> |
|--------------|-----------------------------|---|-----------------------------|
| 1. Attention | Normal _____<br>Alert _____ | Short span, hyper,<br>alert, distractible               | _____<br>_____              |
| 2. Mood      | Normal _____                | Elated, euphoric,<br>agitated, fearful,<br>hostile, sad | _____<br>_____<br>_____     |
| 3. Affect    | Appropriate _____           | Inappropriate,<br>shallow, flat,<br>intense             | _____<br>_____<br>_____     |

**Perception and Thought Content**

|                        | <i>Check if applies</i> | <i>Description</i>   |
|------------------------|-------------------------|----------------------|
| 1. Hallucination       | _____                   | _____                |
| a. Auditory            | _____                   | _____                |
| b. Visual              | _____                   | _____                |
| c. Tactile             | _____                   | _____                |
| d. Gustatory           | _____                   | _____                |
| e. Olfactory           | _____                   | _____                |
| 2. Delusion            |                         |                      |
| a. Paranoid            | _____                   | b. Persecutor _____  |
| c. Grandiose           | _____                   | d. Reference _____   |
| e. Control             | _____                   | f. Thought _____     |
| g. Broadcasting        | _____                   | h. Insertion _____   |
| i. Thought withdrawal  | _____                   |                      |
| 3. Illusions           |                         |                      |
| a. Visual              | _____                   |                      |
| b. Auditory            | _____                   |                      |
| Describe               | _____                   |                      |
|                        | _____                   |                      |
| 4. Other derealization |                         |                      |
| a. Phobias             | _____                   | b. Obsessions _____  |
| c. Compulsions         | _____                   | d. Ruminations _____ |

Describe \_\_\_\_\_  
\_\_\_\_\_

5. Suicide/homicide

Ideation \_\_\_\_\_ Plans \_\_\_\_\_

Describe \_\_\_\_\_  
\_\_\_\_\_

**Orientation** Oriented × 3 Yes \_\_\_\_\_ No \_\_\_\_\_

Disoriented to: Time \_\_\_\_\_ Place \_\_\_\_\_ Person \_\_\_\_\_

**Judgment** Intact \_\_\_\_\_ Impaired \_\_\_\_\_

Describe \_\_\_\_\_  
\_\_\_\_\_

**Concentration/Memory**

1. Memory Intact \_\_\_\_\_ Impaired \_\_\_\_\_

2. Immediate recall Good \_\_\_\_\_ Poor \_\_\_\_\_

3. Reversals Good \_\_\_\_\_ Poor \_\_\_\_\_

4. Concentration Good \_\_\_\_\_ Poor \_\_\_\_\_

**Abstract Ability**

1. Similarities Good \_\_\_\_\_ Poor \_\_\_\_\_ Bizarre \_\_\_\_\_

2. Absurdities Recognized \_\_\_\_\_ Not recognized \_\_\_\_\_

3. Proverbs Appropriate \_\_\_\_\_ Literal \_\_\_\_\_ Concrete \_\_\_\_\_ Bizarre \_\_\_\_\_

**Insight** Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Absent \_\_\_\_\_

\_\_\_\_\_

## Form 4.4: Therapeutic Progress Report

Date \_\_\_\_\_

Therapist's name \_\_\_\_\_

Therapist's phone \_\_\_\_\_

Client's name/ID \_\_\_\_\_

Client's age \_\_\_\_\_ Sex \_\_\_\_\_

Sessions to date with client \_\_\_\_\_  
(dates from/to and total number)

Client's presenting complaint

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Therapeutic summary

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Methods of treatment

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Duration of treatment

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Current status

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Treatment recommendations

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\_\_\_\_\_  
Therapist's signature

\_\_\_\_\_  
Supervisor's signature