

### CDS (Counselor) Referral Form – Parent (Child Development Specialist – Michelle Bolinger)

Date: \_\_\_\_\_ Student Name: \_\_\_\_\_

Urgency: High/Med/Low (circle one)

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Contact Info: \_\_\_\_\_

Student is currently receiving special services: Y N Type of service: \_\_\_\_\_

This issue has been discussed with school staff (teacher/principal/EA): Y N

**\*I give permission for the CDS to meet with my child, individually or in groups:** \_\_\_\_\_  
(Parent/Guardian Signature)

Comments:  
\_\_\_\_\_  
\_\_\_\_\_

**REASON FOR REFERRAL** (check all that apply):

- | <u>Academic</u>                                 | <u>Social/Behavioral</u>                      | <u>Personal</u>                             | <u>Emotional</u>                         |
|---|---|---|--|
| <input type="checkbox"/> Low Grades             | <input type="checkbox"/> Peer Relationships   | <input type="checkbox"/> Family Challenges  | <input type="checkbox"/> Dysregulation   |
| <input type="checkbox"/> Motivation/Attitude    | <input type="checkbox"/> Social Skills        | <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Impulsive       |
| <input type="checkbox"/> Inattention/Distracted | <input type="checkbox"/> Bullying/Bullied     | <input type="checkbox"/> Family Conflict    | <input type="checkbox"/> Anger           |
| <input type="checkbox"/> Disruptive             | <input type="checkbox"/> Physical/Fights      | <input type="checkbox"/> Loss/Death         | <input type="checkbox"/> Stress          |
| <input type="checkbox"/> Dislikes School        | <input type="checkbox"/> Verbal Disrespect    | <input type="checkbox"/> Drugs/Alcohol      | <input type="checkbox"/> Worries/Anxiety |
| <input type="checkbox"/> Absences/Tardiness     | <input type="checkbox"/> Destructive Behavior | <input type="checkbox"/> Personal Hygiene   | <input type="checkbox"/> Trust           |
| <input type="checkbox"/> High Activity Level    | <input type="checkbox"/> Dishonesty/Lying     | <input type="checkbox"/> Health/Illness     | <input type="checkbox"/> Sad/Depressed   |
| <input type="checkbox"/> Adjustment Issues      | <input type="checkbox"/> Withdrawal           | <input type="checkbox"/> Other _____        | <input type="checkbox"/> Self-esteem     |
| <input type="checkbox"/> Skill Deficits         | <input type="checkbox"/> Other _____          |   | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Other _____            |   |   |  |

Please describe your concerns/reasons for referral (you can also use the back of the form if needed):

Student's Strengths and Interests:

\*Referred By: \_\_\_\_\_