



**Referral Form**

**Form Number**

**Review Date: October 2017**

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

Class and Teacher: \_\_\_\_\_

DOB: \_\_\_\_\_

Person Making Referral: \_\_\_\_\_

Name:	Address:	Phone:
Mother: _____	_____	_____

Father: _____	_____	_____
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Guardian: _____	_____	_____
(optional)		

Signature(s): \_\_\_\_\_

Parental/Guardian Consent for Counselling:      Yes/No  
*(Mother and father required only where separated/divorced)*

Principal's Signature: \_\_\_\_\_

Reason(s) for Referral: \_\_\_\_\_  
\_\_\_\_\_

Goal(s) for counselling: \_\_\_\_\_  
\_\_\_\_\_

Other Information (including existing supports): \_\_\_\_\_  
\_\_\_\_\_

**Counsellor's Use Only**

Level of Priority (Please circle):      **Low**      **Moderate**      **Urgent**

Follow Up: \_\_\_\_\_  
\_\_\_\_\_