



Tracy High School Counseling COST Referral Form

Date: _____ Referred by: _____

Student's Name: _____

Grade: _____ ID: _____ DOB: _____

PLEASE COMPLETE AS
MANY DETAILS AS
POSSIBLE AND
RETURN TO THE
COUNSELING OFFICE

NOTE: If you suspect Child Abuse or Neglect **YOU MUST** notify CPS (209)468-1333

REASON FOR REFERRAL: **Reminder: Students with chronic attendance, behavior, social skills or work habits concerns will be targeted for counseling interventions on a regular basis through data-driven methods. Please use this referral for students experiencing sudden or concerning changes in the above, personal problems, or a family crisis.

☐ Change in Attendance ☐ Change in Behavior ☐ Change in Social Skills

☐ Change in Work Habits ☐ Personal/Family Concerns ☐ Other: _____

How long have you had this concern? ☐ 1 Day ☐ A few days ☐ One Week ☐ Two Weeks or More

Please describe your reason(s) for this referral and any additional concerns or information:

Please rate the severity of this referral. On a scale of 1-10, please circle how serious (immediate) this problem is:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Less Serious Moderately Serious Very Serious

Steps taken to address concerns (teachers/staff only):

What interventions are in place? ☐ Parent Conference ☐ Outside Counseling ☐ SST/504/IEP

☐ Discipline Referral ☐ Behavior Contract ☐ Other: _____

Has this issue been discussed with the students' parent/guardian? ☐ No ☐ Yes: date of contact: _____

Outcome of Parent/Guardian Contact (Parent Response or Action):

Please note: This referral will be screened and responded to utilizing a triage approach. The school counselor will provide acknowledgment of receipt and status of referral within 3 business days.