Patient Name: ___________________________

DOB: _______________________

SHAPING CHILDREN FOR THEIR FUTURES

Student's Name: ________________________________ Grade: _______ Homeroom: ________________________

Referred By: ____________________________________ Phone #: ____________________________

Relationship to Student: ____

Parent/Guardian Name(s): ____

Contact Phone Number(s): ____

Has the problem/concern been discusssed with parent(s)/guardian(s)? ☐ Yes ☐ No

If so, what was the response?: ____

____

Are the parent(s)/guardian(s) aware you are making this referral? ☐ Yes ☐ No

If so, what was the response?: ____

____

Special Concerns: (check all that apply)

☐ Distractibility ☐ Hyperactivity ☐ Racing Thoughts ☐ Impulsivity ☐ Defiance

☐ Anxiety ☐ Worry ☐ Panic Attacks ☐ Phobias ☐ Compulsive Behavior

☐ Social Discomfort ☐ Hopelessness ☐ Loneliness ☐ Low Self Worth ☐ No/Few Friends ☐ Withdrawal from people

☐ Wide Mood Swings ☐ Swearing ☐ Lying

☐ Sleep Problems ☐ Nightmares ☐ Fatigue ☐ Poor Memory ☐ Confusion

☐ Destroys Property ☐ Stealing ☐ Manipulative Behavior ☐ Toileting Problems

☐ Sadness/Depression ☐ Thoughts of Death ☐ Self Harming ☐ Homicidal Thoughts ☐ Crying Spells ☐ Lack of Motivation

☐ Legal Problems ☐ Running Away ☐ Sexual Behavior ☐ Work/School Problems ☐ Alcohol/Drug Use

☐ Curfew Violations ☐ Fire Setting

☐ Irritability ☐ Anger ☐ Aggression/Fights ☐ Frequent Arguments ☐ Peer/Sibling Conflict

☐ Hearing Voices ☐ Visual Hallucinations ☐ Suspicion/Paranoia ☐ Obsessive Thoughts

When did the problem begin? ____

____

944 Fields Dr., Suite 102
Bowling Green, KY 42104
(Phone) 1.270.495.1312
(Fax) 1.270.495.1351

121A Casey Street
Campbellsville, KY 42718
(Phone) 1.270.465.7768
(Fax) 1.270.465.0068

529 Westport Rd.
Elizabethtown, KY 42701
(Phone) 1.270.763.8225
(Fax) 1.270.763.8125

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Any medical concerns related to the issue? ☐ Yes ☐ No If so, please describe: _________________________

____

Briefly describe the PRIMARY problem/concern: ____

____

____

____

____

Please provide the 3 BEST DAYS/TIMES for a counselor to meet with student **DURING** the school day:

1st Choice: Day of Week: ______________________ Time of Day: ________________________

2nd Choice: Day of Week: ______________________ Time of Day: ________________________

3rd Choice: Day of Week: ______________________ Time of Day: ________________________

Thank you for this referral. Our goal is to be a part of the team that helps this student grow.
Our office staff will contact the parent/guardian to discuss scheduling this student for an evaluation.

If you think of additional information that you would like to add, please contact us at any of the following:

- **Email: counseling@thekidspotcenter.com**
- **Call: (270) xxx-xxxx**
- **Speak to: The Kid SpOt Center, LLC counselor assigned to your school**

____ ________________________

Teacher Signature Date

*****FOR OFFICE USE ONLY*****

☐ School ☐ Clinic

Therapist Name: ____

Date of Initial Contact with Parent/Guardian: _________________________

Date sent to Patient Advocate: ____________________________