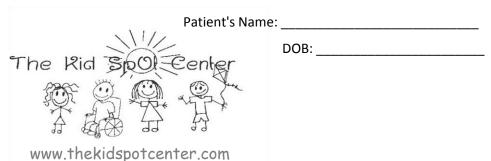


SHAPING CHILDREN FOR THEIR FUTURES

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)/gu	guardian(s)? Yes No
If so, what was the response?:	
Are the parent(s)/guardian(s) aware you are making this refe	ferral?
If so, what was the response?:	
Wide Mood Swings	Compulsive Behavior Low Self Worth No/Few Friends Withdrawal from peop or Memory Confusion avior Toileting Problems arming Homicidal Thoughts Crying Spells Motivation or Work/School Problems Alcohol/Drug Use lent Arguments Peer/Sibling Conflict ion/Paranoia Obsessive Thoughts



SHAPING CHILDREN FOR THEIR FUTURES ☐ Yes ☐ No If so, please describe: Any medical concerns related to the issue? 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: _____ Day of Week: _____ Time of Day: _____ 2nd Choice: Day of Week: _____ Time of Day: ____ 3rd Choice: 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***