School Counseling Referral Screen

A "Yes" to any of the following symptoms would suggest a referral to the school based therapist for possible involvement in school based services.

Please give form to school based therapist or email to Shea Christensen **at** schristensen@icsmail.org.

SYMPTOM	YES	NO
Prior diagnosis of depression, anxiety or mood disorder	☐	☐
Youth is currently on any psychotropic medication	☐	☐
Sad or depressed emotionally	☐	☐
Very irritable emotionally	☐	☐
Withdraws/avoids contact with others	☐	☐
Sleep difficulties	☐	☐
Trouble concentrating/staying focused	☐	☐
Inability to control him/herself	☐	☐
Substance use	☐	☐
Past/Current trauma	☐	☐

Youth's Name: _____

Referral name and position: _____

Date of referral: _____ ***Parent has been contacted:** Yes ☐ No ☐

Age: _____ **Date of Birth:** _____ **Grade:** _____ **Gender:** _____

Reason for referral/recommendations: _____

_____

Parent/Guardian contact information:

Name: _____

Address: _____

_____

Phone: _____

* If the child is under the age of 12, Illinois State law requires parental consent before conducting any counseling sessions. If this is the case, please contact the parent/guardian to inquire whether they are interested in pursuing services before turning in referral.