



## Palliser Regional Schools FAMILY SCHOOL LIAISON COUNSELLING REFERRAL FORM

STUDENT NAME: \_\_\_\_\_ DATE REFERRED: \_\_\_\_\_

AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ HOMEROOM TEACHER: \_\_\_\_\_

MOTHER: \_\_\_\_\_ Lives with:  Mail to:   
Name/ Phone

FATHER: \_\_\_\_\_ Lives with:  Mail to:   
Name/ Phone

Custody: \_\_\_\_\_ Obtained verbal parental consent

ADDRESS: \_\_\_\_\_  
(PO Box No.) (Street Address)  
\_\_\_\_\_  
(Town/Village/City) (Province) (Postal Code)  
\_\_\_\_\_  
(Legal Land Description)

TELEPHONE /EMAIL: \_\_\_\_\_

### **STUDENT CONCERNS: please highlight or circle appropriate descriptors**

Abusing others	Dating relationship	Friendship problems	Obsessions	Social skills
Academic concerns	Decision-making	Low self-esteem	Physical abuse	Stress
Lack of ambition	Depression	Lack of energy	Physical ailments	Substance abuse
Anxiety	Divorce/separation	Loneliness	Poor concentration	Suicidal thoughts
Anger/acting out	Drug / alcohol abuse	Looks/acts tired	Sadness	Work habits
Attendance	Eating disorders	Loss/grief	Self-control	
Attention problems	Emotional abuse	Memory problems	Self-harm	
Bullied by others	Family concerns	Nervous/irritable	Sexual concerns	
Bullying others	Fears	Nightmares	Sleep/insomnia	

Additional information or concerns: (If there has been previous involvement by other agencies, etc., please describe/explain.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TEACHER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINCIPAL'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_