HENRIETTA WEILL MEMORIAL
CHILD GUIDANCE CLINIC
& ADULT BEHAVIORAL HEALTH

REFERRAL FOR COUNSELING SERVICES

CHILD'S PRIMARY LANGUAGE: ____________ GUARDIAN'S PRIMARY LANGUAGE: ____________

REFERRING PARTY INFO

DATE: ____________ GRADE: ______ SPEC EDUCATION: ☐ YES ☐ NO

SCHOOL: ____________ SCHOOL COUNSELOR: ____________

ROOM #: ____________ REFFERING PARTY'S EMAIL: ____________

TEACHER: ____________ Email address for others who should receive information regarding thsi referral : ____________

PLEASE CONTACT PARENTS FIRST: ____________

Have you informed the guardian that a mental health referral has been made? ☐ YES ☐ NO

REFERRED PARTY INFO

NAME: ____________ SOCIAL SECURITY # ____________

DOB: ____________ GENDER: ☐ Male ☐ Female

ADDRESS: ____________ ZIP: ____________ PHONE#: ____________

LEGAL GUARDIAN: ____________ RELATION: ____________

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DHS SOCIAL WORKER/ PROBATION OFFICER: ____________

BRIEF DESCRIPTION OF PRESENTING PROBLEM: ____________

SYMPTOMS, PLEASE CHECK ALL THAT APPLY

DEFIANCE: ☐ loses temper ☐ argues ☐ defiant ☐ angry ☐ resentful ☐ annoying ☐ spiteful ☐ hits

SERIOUS CONDUCT BEHAVIORS: ☐ cruel to animals/ people ☐ fights ☐ steals ☐ sexual misconduct ☐ deceitful ☐ runaway ☐ criminal behaviors ☐ gang affiliation ☐ drug abuse ☐ alcohol abuse ☐ homicidal ideation

ATTENTION PROBLEMS: ☐ inattention ☐ distractable ☐ forgetful ☐ hyperactive ☐ poor concentration ☐ fidgets ☐ inappropriate activity ☐ impulse ☐ blurts out ☐ interrupts

MOOD AND EMOTIONS: ☐ depressed ☐ hopeless ☐ helpless ☐ withdrawn ☐ cries ☐ irritable ☐ suicidal ideation ☐ isolates self ☐ sleep increase/decrease ☐ poor concentration ☐ appetite increase/ decrease

STRANGE BEHAVIORS: ☐ delusions ☐ hallucinations ☐ paranoia ☐ isolates self ☐ "lost in their own world"

AREAS FUNCTIONALLY IMPAIRED DUE TO SYMPTOMS, PLEASE CHECK ALL THAT APPLY

☐ school/education ☐ social relationships ☐ home/family relationships ☐ physical health ☐ **independent living**

DISPOSTION (FOR OFFICE USE ONLY)

REFFERING PARTY'S EMAIL: ____________

____

ASSESSMENT DATE: ____________ THERAPIST: ____________ REFERRING PARTY INFORMED: ______