



STUDENT REFERRAL FORM

Counselling Services

PRIORITY: __LOW (schedule when available) __ HIGH (schedule as soon as possible) __ EMERGENCY (see now)

Student's Name: _____

Please Print

Last

First

Middle

Sex: Male _____ Female _____ Date of Birth: _____

School: _____ Grade: _____

Referred By: __ Teacher __ Guidance Counselor __ Guardian Other _____

Reason(s) for Referral/Presenting problems/Concerns related to: (Please check all that apply.)

- Academics (Marks, failing, comprehension)
- Abuse(Sexual, physical, emotional, mental)
- Attendance (Absence, lates, etc.)
- Attitude
- Anxiety/Nervous
- Suicidal Ideations/attempts
- Self Harming Behaviour
- Dramatic change of behaviour
- Dropout risk
- Socially unacceptable behavior - sexually acting out/vandalism etc.
- Problems with relationships (peers, school personnel, families)
- Depression
- Grief & loss
- Lack of interest or motivation
- Inappropriate expression of anger
- Self-esteem issues
- Bullying/Cyberbullying
- Child protection involvement
- Unresolved past issues
- Dealing with trauma
- Drugs & Alcohol
- Risky behaviours resulting in safety issues
- Family Issues (addictions,violence, divorce, separation and/or abuse)

Reason for Referral: Please indicate any other relevant information

Referred By: _____ Date Referred: _____

MLTC Signature: _____ Date Received: _____

Services provided / Follow up Date: _____

Guardian/ Parent Name & Contact Information: _____



Parental Consent for Counselling Services

- Has been referred to or has been receiving other MLTC or community Mental Health Counseling and/or any other outside service supports. Please indicate other services provided: _____

I, the parent/guardian of _____ hereby give consent to MLTC Education Clinical Team Support Worker(s) to provide ongoing counselling services for my child.

I also understand that this consent will be valid until the end of the current school year or until such permission is rescinded by me, the student or the parent in writing and submitted.

Signature: _____ Date: _____

(Parent/Guardian signature)

Consent to Obtain and Release Information

I, the parent/guardian of _____ hereby give consent to MLTC Education to disclose any information necessary for case consultation, case management, and third party reporting to the following people or agencies:

- MLTC Mental Health
 MLFN Community Services
 Addictions Services
 Other _____

Signature: _____ Date: _____

(Parent/Guardian signature)

Background Information Counselling Services
(To Be Given Directly To Clinical Support Worker)

1. Has your child been referred to or has/have been receiving other MLTC or community Mental Health Counseling and/or any other outside service supports? ___ YES ___ NO

If YES please indicate services: _____

1. What are your concerns at school or at home?(Please include any information you think would be beneficial for the counsellor to be aware of)

2. Has your child ever been exposed to violence or experienced a trauma?(witnessed abuse, death of a loved one, natural disaster) If yes, please describe:

3. Please list any other significant background information that may affect your child. (ie: disabilities, allergies, medications, general health/diet, family situation/dynamics, relevant family health history)

4. Are there any other agencies/services involved with the child/family?

***Please feel free to contact the Clinical Team Support Worker with any other information you may want to share or any questions or concerns you may have.**