SCHOOL COUNSELLOR REFERRAL FOR REFERRAL OF STUDENT BY PARENT/GUARDIAN CONFIDENTIAL * See Notice Below

Your Child's Name:
DOB: / / Year:
Address:
Phone Numbers: Home Work/Mobile
Your name & relationship to child
Your partner's name living at home and his/her relationship to child:
Siblings' names:
Privacy Notice : This information is being obtained to assist the school counsellor in supporting your child. It may be appropriate to provide information in this referral to other school staff. Provision of this information is voluntary. It will be stored securely. You may amend any information at a later time by contacting the school counsellor.
Reason for Referral: What are the main concerns and how long have you held these concerns about your child?
1. To enable student to meet with the counselor and understand her role in the school
2
3
4

Is your child's teacher, principal or other school staff aware of your concerns? Yes / No
Has or does your child have any of the following problems? Please circle
* Speech/Language problems
* Behavioural disorders (such ADHD)
* Vision Problems
* Hearing Problems
* Other Notable Medical Problems
* Other Problems
What assessments and/or interventions have been used either at school or outside of school to address these problems? Please circle
* Medical Specialist / Paediatrician * Speech Therapist * Occupational Therapist * Psychologist / Child Psychiatrist * Other School Counsellor * Optometrist / Audiologist
Please provide brief information about the above or any other professional involved:
I give permission for the School Counsellor to interview & /or assess my child
as appropriate
Signed Date / /

Thank you for completing this referral. You will be contacted to arrange a more in depth discussion and feedback of assessment results with the School Counsellor Ms. Erika Ellis.