EUROPEAN SCHOOL KARLSRUHE - SCHOOL PSYCHOLOGIST REFERRAL FORM

Date Received: _____ Signature that it was received by School Psychologist: _____

PRIORITY:

Low (schedule when available): ☐

High (schedule as soon as possible): ☐

Emergency (see now): ☐

Student Name: _____ Grade/Class: _____

Teacher Name: _____ Parent/Guardian Name: _____

Phone: _____ Email: _____

Referred by: Teacher ☐ Date of Birth: _____

Parent ☐

Self ☐

Other ☐

Reasons for Referral – Problems/Concerns related to: *(Please check all that apply)*

Change in behavior	☐	Cries easily for age	☐	Hyperactive	☐
Worries	☐	Self-image/confidence	☐	Easily distracted	☐
Daydreams	☐	Social skills	☐	Sexual/Gender Identity	☐
Grief	☐	Nerves/Anxiety	☐	Peer relationships	☐
Fears	☐	Aggression/Anger	☐	Personal hygiene	☐
Sadness	☐	Swearing	☐	Family concerns	☐
Always tired	☐	Fighting/Physical Violence	☐	Academic performance	☐
Motivation	☐	Lying	☐	Absences	☐
Inattentive	☐	Bullying	☐	Other: _____	
Withdrawn	☐	Self/harm	☐		

Clarify / Elaborate on Problem / History:

_____

_____

_____

Actions taken by the person referring this student, if applicable: (*please attach copies of any interventions*)

_____

_____

Have parents/guardians been contacted (*if applicable*)? YES/NO Date: _____

Explain the outcome of parent contact (*if applicable*): _____

_____

_____ _____

Signature of Person Making Referral Date Signed