SANTO NINO REGIONAL CATHOLIC SCHOOL

COUNSELING REFERRAL FORM

DATE ___________________________________

STUDENT ____

TEACHER _______________________________**GRADE**_________________

REASON FOR REFERRAL

____

____

PERSON MAKING REFERRAL:____

ACTION ALREADY TAKEN ____

NEED: _____**IMMEDIATE** _____**WITHIN TWO WEEKS**

PARENTS _____**CONTACTED** _____**NEED TO BE CONTACTED**

*****Parents Names and Phone Numbers:**

Mom:__________________________**Work#**__________________**Cell#**____________
__ ***(name)***

Dad:____________________________**Work#**__________________**Cell#**___________
__ ***(name)***

Other:

COUNSELING PROVIDED BY KATHERINE THRIFT, LPCC. Please fold this form, staple it and place it in the counselor's mailbox in the mailroom. Thank you!