**LBMS COUNSELOR REFERRAL**

NAME OF PERSON MAKING REFERRAL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_

REASON FOR REFERRAL: (please select all that apply)

* Personal Concerns
* Family Concerns
* Peer Relations
* Academic/Grades
* Absences
* Other \_\_\_\_\_\_\_\_\_\_\_\_

Please tell me more if needed…\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\*\*\*\*\*\*\*\*\*\*\*\*\*\*DO NOT WRITE BELOW THIS AREA—COUNSELOR USE ONLY\*\*\*\*\*\*\*\*\*\*\*\*\*\*

* Resolved
* Individual Counseling
* Group Counseling
* Parent Contacted
* Referral-Administration
* Referral-Frontier Health