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| **Teacher’s Counselling Referral Form** |
| Date: |  | Name: |  |
| Class: |  | Teacher: |  |
| School: |  |
| Priority: | ☐ Urgent, must see ASAP | ☐ Important | [ ]  Standard |
| Reason for referral:Please include any behaviours noted, situations that have occurred etc. |  |
| Relevant history:Please include school, social, and family history if known. |  |
| Medications: |  |
| Please check any problems, suspected (S) or confirmed (C):  | ☐ Stress  | [ ]  Anxiety | ☐ Depression | ☐ Anger |
| ☐ Grief & Loss | ☐ Trauma | ☐ Illness | ☐ Work/School |
| ☐ Bullying | ☐ Relationship/Family | ☐ Child Abuse/Neglect | ☐ Autism Spectrum Disorder |
| ☐ ADHD/ADD | ☐ Family Violence | ☐ Disability | ☐ Other |
| Thank you for your time. Please do not hesitate to contact me on 0458 382 569 or at mel@phoenixwingswellness.com.au with any questions. |