



**Parent/Guardian Referral form for Counselling Services**

*Please complete one form per student. Each student will be seen as soon as possible and in the order of seriousness/urgency.*

Student's name \_\_\_\_\_ Date referred \_\_\_\_\_

Person referring student \_\_\_\_\_ Phone No. \_\_\_\_\_

**Check area of concern:**

- \_\_\_\_\_ Attitude towards School
- \_\_\_\_\_ Home/Family
- \_\_\_\_\_ Behaviour at Home
- \_\_\_\_\_ Behaviour while Family Gatherings
- \_\_\_\_\_ Other
- \_\_\_\_\_ Homework
- \_\_\_\_\_ Peer Relations
- \_\_\_\_\_ Attitude towards Faculty/Staff relations
- \_\_\_\_\_ Study Skills

Detailed description of reason for referral (Kindly be Specific)

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Please list any goals you have for your child to work on during counselling

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Observation Requested? **YES**  **NO**

\_\_\_\_\_ (Parent/Guardian signature)

*Thank you for your cooperation.  
Dr. Nafeesa Khurshid  
School Counsellor*

**For office use only:**