

CONFIDENTIAL

Buffalo Grove High School STUDENT SUPPORT TEAM REFERRAL FORM

Student _____ ID# _____ Grade In School _____ Date _____

Teacher _____ Class _____ Period _____

BEHAVIOR/SYMPTOMS:

- | | |
|--|--|
| <input type="checkbox"/> Personality/emotional changes | <input type="checkbox"/> Sleeps in class |
| <input type="checkbox"/> Irresponsible/loses things | <input type="checkbox"/> Lethargic/blank stares |
| <input type="checkbox"/> Hyperactive/nervousness | <input type="checkbox"/> Withdrawn/loner |
| <input type="checkbox"/> Cries in class | <input type="checkbox"/> Frequently/easily upset |
| <input type="checkbox"/> Argumentative/defensive | <input type="checkbox"/> Frequently exchanges money with others |
| <input type="checkbox"/> Frequently teased/bullied | <input type="checkbox"/> Wears drug-related clothing/jewelry |
| <input type="checkbox"/> Makes inappropriate comments/jokes | <input type="checkbox"/> Bloodshot eyes/wears sunglasses indoors |
| <input type="checkbox"/> Inappropriately displays affection | <input type="checkbox"/> Smells of alcohol/drugs |
| <input type="checkbox"/> Changes in friends | <input type="checkbox"/> Frequently asks to leave classroom |
| <input type="checkbox"/> Older/Younger peer group | <input type="checkbox"/> Denies problem despite evidence/lies |
| <input type="checkbox"/> Poor hygiene/signs of neglect | <input type="checkbox"/> Police/court involvement |
| <input type="checkbox"/> Sudden change in appearance or weight | <input type="checkbox"/> Deteriorating Grades |

SPECIFIC CONCERNS:

- | | |
|---|---|
| <input type="checkbox"/> Talks about home problems | <input type="checkbox"/> Has difficulty making friends |
| <input type="checkbox"/> Has run away | <input type="checkbox"/> Sexual Issues |
| <input type="checkbox"/> Talks about alcohol/drug use | <input type="checkbox"/> Teen parent |
| <input type="checkbox"/> Others talk about student's alcohol/drug use | <input type="checkbox"/> Talks about hurting self |
| <input type="checkbox"/> Talks constantly of parties | <input type="checkbox"/> Talks about hurting others |
| <input type="checkbox"/> Live with chronically/terminally ill person | <input type="checkbox"/> Gang Involvement |
| <input type="checkbox"/> Current/past hospitalization | <input type="checkbox"/> Alleged Abuse |
| <input type="checkbox"/> Relative/friend has died | <input type="checkbox"/> Alcohol/drug problem in the family |
| <input type="checkbox"/> Home condition/living situation | <input type="checkbox"/> Concerned person has made contact |

OTHER INFORMATION:

PLEASE NOTE: All cases of suspected child abuse, suicide, threat to others, or sexual assault MUST be reported to the counselor, psychologist or social worker immediately.

Please add additional comments on the reverse side. Although the information you share may be used to assist the student, your name will not be used without your consent. Please initial here for consent _____.

Return this form in a confidential manner (sealed envelope or hand-delivered) to the counselor, psychologist or social worker (see reverse side).

Referred by _____