



# Catholic Education

Diocese of Rockhampton

## School Counselling Referral

### Referrer Details:

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Contact Details: (Phone, Email) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Details of Student:

Name of child: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Male/Female: \_\_\_\_\_

School: \_\_\_\_\_ Year Level: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_

Is the child of Aboriginal and/or Torres Strait Islander origin?    Yes    No

Has the child had previous assessments or diagnoses?    Yes    No    Unknown

If yes, please give details:

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### Reason for Referral/Concerns:

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**Parent/Carer 1:**

Name: \_\_\_\_\_ Relationship with child: \_\_\_\_\_

Contact Details (Phone/email): \_\_\_\_\_

**Parent/Carer 2:**

Name: \_\_\_\_\_ Relationship with child: \_\_\_\_\_

Contact Details (Phone/Email): \_\_\_\_\_

***Please circle:***

Do both parents/guardians know of and agree to the counselling referral? Yes / No / Unknown

Are parents separated? Yes / No / Unknown

Are Family Court Orders/Protection Orders/ Parenting Plans in Place? Yes / No / Unknown

If yes, please specify: \_\_\_\_\_

***Parent/Guardian Consent (At least one signature required):***

In signing this, I also acknowledge that I have read and understood the information provided (see *Counselling Information for Parents/Carers*) about the school counselling service as well as the limitations to privacy and confidentiality. I understand that once given, my consent will remain current until it is withdrawn in writing by me.

I, \_\_\_\_\_ (Parent/Guardian) consent to the school counsellor providing services to \_\_\_\_\_ (Child's name).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I, \_\_\_\_\_ (Parent/Guardian) consent to the school counsellor providing services to \_\_\_\_\_ (Child's name).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_