Lake Shore CSD Social Work Referral-CONFIDENTIAL

Student Name:_____ D.O.B._____ Today's Date:_____

School:_____ Counselor:_____ Referred By:_____

Reason For Referral:

__Mental Health Hospitalization __Suicide Attempt/Ideation

__Mental Health Diagnosis __Other:_____

Details:_____

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I have addressed this issue since by:

__Met with student __Referred to Family Support __Linked to outside agency

__Parent Phone Call __Referred to Community Concern/Counseling

__Parent Conference __Referred to outside agency services __Conference with School Counselor

__Other:_____

School Counselor Signature:_____

Administrative Signature:_____

Please send or email this to Keri Fisher: kfisher@lakeshorecsd.org PH:926-2381 FAX:541-1904