

LAKE SHORE CSD Family Support Center Referral-CONFIDENTIAL

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

School: _____ Counselor: _____ Referred by: _____

BASIC NEEDS

Please check all that apply and hand this form into Keri Fisher K-8th or Brian Kelley 9th-12th

Medical Insurance Housing Food Pantry Clothing Other: _____

AGENCY COUNSELING or REFERRAL: Please Check Reason for Referral (Check all that apply)

Grief/Loss Teen Pregnancy/Parenting Drug/Alcohol Abuse
 Mental Health Concerns (anxiety, depression, eating disorder, self-injury/harm, cutting)
 Divorce, separation, change of guardian Other: _____

What steps have been taken to address the concern:

Student has been seen by school counselor (result: _____)
 Student has been seen by school psychologist (result: _____)
 Phone call home (result: _____)
 Parent Conference (result: _____)
 Other: _____

What services are being requested:

Referral to Gateway, CATS, or Community Concern Referral for substance abuse treatment
 Referral to outside agency counseling Referral to Anxiety Group in HS
 Referral to Grief/Loss or Family Change Group in Elementary Schools
 Other: _____

Comments: _____

****Signature ONLY needed for Counseling Referral NOT Basic Needs****

Counselor Signature: _____ Administrative Signature: _____

For K-8th grade please submit this form to: Keri Fisher PH: 926-2381 Email: kfisher@lakeshorecsd.org

For 9th-12th grade please submit this form to: Brian Kelley PH: 926-2323 Email: bkelley@lakeshorecsd.org