



Mental Health Support Request

Name of student: _____ Date: _____

Referred by: _____

Relationship to student: Teacher/Staff Parent Friend Self

Completed by: _____

Were Parents contacted? Yes, or No If yes, Date _____

Area of concern (please describe):

- Behavioral Concerns:
- Social Concerns:
- Emotional Concerns:
- Physical Health Concerns:
- Family Concerns:
- Other: _____

Behavioral/emotional concerns (please mark all boxes that apply):

- | | |
|--|--|
| <input type="checkbox"/> Exposed to community violence, other trauma | <input type="checkbox"/> Low self-esteem, negative self-statements |
| <input type="checkbox"/> Nightmares, intrusive thoughts | <input type="checkbox"/> Diminished interest in activities |
| <input type="checkbox"/> Anxious, fearful or irritable mood | <input type="checkbox"/> Low or decreased motivation |
| <input type="checkbox"/> Jumpy or easily startled | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Avoids reminders of trauma | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Specific fears or phobias |
| <input type="checkbox"/> Sexualized play or behaviors | <input type="checkbox"/> Clingy behavior |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Appears distracted |
| <input type="checkbox"/> Talks excessively | Additional information |
| <input type="checkbox"/> Gets out of seat and moves constantly | <input type="checkbox"/> Death of a family member |
| <input type="checkbox"/> Interrupts and blurts out responses | <input type="checkbox"/> Parents' divorced/remarried |
| <input type="checkbox"/> Inattentive, distractible, forgetful | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Disorganized, makes careless mistakes | |
| <input type="checkbox"/> Angry towards others, blames others | |
| <input type="checkbox"/> Fights and is aggressive | |

How long has this behavior/emotion been observed? (e.g., several weeks, several months)

- Less than 30 days
- 30 - 60 days
- 60- 90 days
- > 90 days

How often is this behavior /emotion observed? (e.g., several times per day; 1-2 times per week)

- Monthly; Number of times: _____
- Weekly; Number of times: _____
- Daily; Number of times: _____

To your knowledge, what interventions have previously been tried and/or are currently in place?

- In school supports:

- Outside of school supports:

Additional mental health concerns:

Return completed form to: Certified School Counselor or School Based Social Worker

Outcomes/Interventions: _____
