

**Alternatives, Inc.
Referral/Disposition Sheet**

Student's Name: _____ DOB _____

Referral Source: _____ Referral Date: _____

Division: _____ Lunch period: _____ Circle one: **Roosevelt** **Senn H.S.** **Senn AA** **Rickover**

STUDENT'S IDENTIFIED PROBLEMS: (To be completed by staff person making referral)

Priority referral: ___ Suicidal Ideation ___ Depression ___ Physically Abused* ___ Sexually Abused*
(*As a mandated reporter, please call 1-800-25-ABUSE to report suspected or disclosed abuse.)

I have spoken to the student about this referral and the student has expressed an interest in receiving counseling services. ___ Yes ___ No

If we are unable to make contact with the student at school, is there a number where we would be able to contact the student in order to follow up on this referral? (_____) _____

Would the student be interested in group counseling at school? ___ Yes ___ No

Would the student be interested in counseling services at our main office? (4730 N Sheridan Road)
___ Yes ___ No

Is the student a recent immigrant? ___ Yes ___ No

Student's Primary Language: _____ Parent's Primary Language: _____

Signature: _____

DISPOSITION: (To be completed by therapist)

Student interested in counseling.

Group Counseling	Start Date: _____
Individual Counseling	Start Date: _____
Student referred out:	Agency/Therapist: _____
	Date Referred out: _____

Student not interested in counseling at school.

List of referral numbers given to student. Date: _____ Student has outside therapist

Unable to contact student.

Attempts made: _____ / _____
List of referral numbers sent through division or mailed.

Comments: _____

For Alternatives, Inc. Staff: Student notified of referrals/wait list (write in date): _____.

Signature: _____ **Date** _____