CONFIDENTIAL

School Psychology Referral Form
Parent/Guardian

General Student Details **Date:**

Student Full Name:	Preferred name:
Gender: Male ☐ Female ☐ Other ☐	
DOB:	Year Level:
1. Parent/Carer name:	2. Parent/Carer name:
Phone:	Phone:
Email:	Email:

Is the student aware of this referral? Yes ☐ No ☐ (Please note that the young person needs to agree to seeing the school psychologist)
Is the student connected with any external professionals or agency's? Yes ☐ No ☐ Details:

Referral Reason:
Please describe the reason for referral to the School Psychology Service and any relevant background information:

What outcome do you hope for from this referral?

Parent signature: **Date:**

Please place the completed form in a sealed envelope and leave it with the front office to be collected by the school psychologist or email to elise.watson@ed.act.edu.au