Inner Sydney High School

REFERRAL TO SCHOOL COUNSELLOR/PSYCHOLOGIST

For completion by **PARENT OR CAREGIVER**

Privacy Notice: This information is being obtained to assist the school counsellor in providing support for your child. It may, as appropriate, be provided to other members of the school staff involved in supporting your child. Provision of this information is voluntary. It will be stored securely. You may correct any personal information provided at any time by contacting the School Counsellor/Psychologist.

Student's Name: _____

Date of Birth: _____

Year/Grade: _____

Date of Referral: _____

Reason for referral/what concerns do you have?

Development history (e.g. Has your child ever been seriously ill or had an accident?)

Previous assessments: e.g. Dr, Psychologist, Speech Therapist (Please say who and attach copies of reports if possible)

Is there anything else you would like the School Counsellor/Psychologist to know?

What do you hope will happen as a result of the School Counsellor/Psychologist seeing your child?

My child is aware of and has agreed to this referral? **YES / NO**

I have read the Privacy Notice and give permission for the School Counsellor/Psychologist to:

Carry out assessment and counselling as required: **YES / NO**

Contact and exchange information and reports with the agencies list of the next page: **YES / NO**

Parent / Caregiver's name: _____

Signature: _____ Date: _____

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CONSENT TO EXCHANGE INFORMATION

I, _____ give permission for the NSW Department
(print name of parent / carer)

of Education School Counsellor/Psychologist, to contact and exchange information about my child,

_____, with the following agencies / services
(print name of child)

(print names of agencies / services below):

Name & Type of Service (e.g. Dr Smith, Paediatrician)	**Phone Number**

Signature: _____

Date: _____

(This consent is valid for 12 months from the above date)