

DEAN OF STUDENTS' COUNSELLING REFERRAL FORM

To: **Counselling Office**

Date: / /
Day Month Year

PERSONAL INFORMATION

Full Name: / /
First Name Middle Name Family Name

Student ID: LAU Email: Mobile No.:

Degree: Major/Emphasis:

OBSERVATIONAL BEHAVIOR

Kindly highlight your observation about the student

Worry, fear, trembling, muscle tension, hot flashes, eye blinking to unexpected or sudden noise or movement... <input type="checkbox"/>	During tests/exams: Excessive sweating, fear, fidgety, vomiting, stomach pain.... <input type="checkbox"/>	Fatigue, sadness, loss of interest in activities, pessimism, changes in physical appearance (unkempt), slow movements... <input type="checkbox"/>
Unable to think with your normal level of clarity, disrupted attention, agitation, confusion, seeing or hearing things that aren't there... <input type="checkbox"/>	Red eyes, chills & sweating, involuntary shaking, behavior changes, teeth clenching, difficulty focusing, confusion... <input type="checkbox"/>	Attention/concentration problems, forgetfulness, difficulty with reading/writing, difficulty with remembering... <input type="checkbox"/>
Disrespect, violence, swearing, threats, irrelevant remarks (i.e., about your personal appearance)... <input type="checkbox"/>	Arrogance, exaggerated self-opinion (i.e., unrealistically powerful, important), inflated self-esteem... <input type="checkbox"/>	Crying, nail biting, poor eye contact, talking fast, walking fast, agitation, procrastination... <input type="checkbox"/>
Lack of motivation, rapid mood changes, emotional numbness, isolation, lack of spontaneous interaction... <input type="checkbox"/>	Bizarre bodily movements, unable to speak, move or respond; unnatural motor behavior... <input type="checkbox"/>	Resistance, rejection of authority, refusal to comply with requests or rules, constant arguments, lying... <input type="checkbox"/>

COMMENTS REGARDING REFERRAL

Determination:

Signature:

Date: / /
Day Month Year