Student Counseling Center Referral Form

Student's Name: _____
Student ID # or DOB: _____

Reason for Referral:

_____
_____
_____
_____
_____

Referred by: _____
Phone: _____ Email: _____
Follow up required: _____ yes _____no By: _____
(date)

(If yes, please indicate the type of follow up required):

_____
_____

Type of Intervention
Appointment needed: ___ immediate ___ 1-2 days ___ within 5 days ___ next available

Additional Information:

_____
_____
_____
_____

Name of person taking referral: _____

Appointment scheduled for: _____
(date and name of counselor)