GreenHeart Medical University

CONFIDENTIAL SCHOOL COUNSELOR REFERRAL FORM

PRIORITY:

___ Low (schedule when available)

___ High (schedule as soon as possible)

____ Emergency (see now)

Student's Name: _____Semester Level: _____

First Last

Contact Details: Cell Ph. _____Home Ph. _____ Email. _____

Request to see the counselor is being made by:

Student ☐ Parent ☐ Lecturer ☐ Administrative Staff ☐ Other ☐

Have you received any counselling, psychiatric or psychological treatment before, which was external to the University? (eg. Private Counselling) Yes ☐ No ☐

Reason for referral to counseling:

_____

_____

_____

_____

_____ _____

Signature of Person Making Referral **Date of Referral**