



SHAW
UNIVERSITY
Celebrating Excellence Since 1865

Counseling Center

REFERRAL FORM

Name of Student Referred

Student's ID Number

Student's Phone Number

Check services needed below:

- | | | |
|--|--|---|
| <input type="checkbox"/> One-to-one Counseling | <input type="checkbox"/> Group Counseling | <input type="checkbox"/> Grief Counseling |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Conflict Resolution/Mediation | <input type="checkbox"/> Hygiene Care |
| <input type="checkbox"/> Behavior Modification | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Acting out in Class | <input type="checkbox"/> Alcohol & other Drugs
(Refer to Substance Abuse Counselor's Procedure) | <input type="checkbox"/> Other |

Reason for referral: _____

Actions take prior to referral: _____

Medications (if known): _____

Follow-up information/recommendation: _____

_____ Name of Referrer	_____ Date Submitted
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