STUDENT WELLNESS SERVICES
MULTIDIS CIPLINARY REFERRAL FORM

STUDENT DEMOGRAPHICS	FROM:		TO:	
Name: __z_____	F	Counselling	F	Counselling
		Case Management	F	Case Management
Student ID#: ___ z z_____	F	Physician		Physician
	F	Other:	F	Other:

A) DIAGNOSIS/RELEVANT HISTORY/BACKGROUND

* If there are risk factors present please describe. This form is NOT to be used for emergency purposes

	Present

E) PURPOSE FOR REFERRAL

Health Services		Mental Health Services (Counselling)		Case Management	
F	Medication Management	F	Initial Assessment	F	Connection to Resources
				F	Harm Reduction Support (Substance use)
F	Other:	F	Other:	F	Other:

F) FEEDBACK F Outcome of assessment F Not Required F Other: