UNIVERSITY OF CALGARY

STUDENT WELLNESS SERVICES
MULTIDISCIPLINARY REFERRAL FORM

STUDENT DEMOGRAPHICS	FROM:		TO:	
Name: ________________________	☐	Counselling	☐	Counselling
Student ID#: ____________________		Case Management	☐	Case Management
	☐	Physician		Physician
	☐	Other:	☐	Other:

A) DIAGNOSIS/RELEVANT HISTORY/BACKGROUND

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

B) GOAL(S) FOR REFERRAL

C) IS THE STUDENT CURRENTLY WORKING WITH A MENTAL HEALTH THERAPIST?

☐ **Yes** (If yes, include details below)

☐ **No**

D) OTHER TREATMENT AND/OR RESOURSES INVOLVED - *List all relevant on and off campus resources (i.e. Student Accessibility Services, Therapist, Group Support, Access Mental Health etc.)*

Past	Present

E) PURPOSE FOR REFERRAL

Health Services		Mental Health Services (Counselling)		Case Management	
☐	Medication Management	☐	Initial Assessment	☐	Connection to Resources
☐	Physical Symptom Assessment	☐	Group Support: Anxiety / Mood/ Social Anxiety	☐	Housing/Food/Finance
☐	Psychiatric Symptom Assessment			☐	Harm Reduction Support (Substance use)
☐	Other:	☐	Other:	☐	Other:

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

G) SIGNATURE

Name (printed):	Signature:	Date: