SWS In-House Referral Form

Date _____ Student Name _____ A# _____

Name Used _____ Pronouns Used _____ Phone _____

From: _____ To: ☐ Counseling ☐ Medical ☐ CC (copy ins. card) ☐ OSVPR

Assigned? Y N To Whom? _____ Seen *only* in Triage / Eval & Referral Y / N

PHQ-9 _____ / _____ GAD-7 _____ / _____ AUDIT _____ / _____ CHI Form Completed Y / N

Desired Timeframe: ☐ 24 hr (talk first & make copies) ☐ 1 week (talk first & make copies) Keep at FO for follow-up ☐ 2+ weeks Keep at FO for follow-up

Brief history of problem: (to be filled out and signed by referring party)

Interests / Needs:

☐ Medical: ☐ Herbs only ☐ Western only ☐ Herbs and Western ☐ PSM

☐ Counseling: ☐ Evaluation & Referral ☐ 7-C (individual only) ☐ Group(s) _____

☐ Care Coordination: ☐ Insurance ☐ PCP ☐ Psychiatrist ☐ Therapist

☐ OSPVR

Current/Interim plan:

Request: Please evaluate and treat/recommend treatment(s)

Signature of referring party: _____

Feedback: (to be filled out by provider receiving referral)

Signature of provider given referral: _____ Date _____

☐ Yellow copy made

Feedback received by referring party: Initials _____ Date _____