FISK UNIVERSITY COUNSELING CENTER

REFERRAL FORM

Student Name: __________________________ Date: _______________
Email Address: __________________________
Student Classification: __________________
Student Phone Number: __________________
Gender: __________________________

Residence:    ___On Campus      ___ Off Campus        ___Other

Person Making Referral: ____________________ Phone: __________________

Reason for Referral (Check All That Apply)

____Personal/Family    ____OTHER (Please Explain __________________________
____Grief
____Residence Hall Concern(s)
____Learning Difficulties
____Alcohol/Substance Abuse
____Academic
____Test Anxiety
____Financial Challenges
____Relationships
____Medical
____Threat to self/others

For Office Use Only
Follow Up: ________________________________________________
Appointment Date ______ Time: ______ Counselor’s Initials ___________________