Counseling Services CAMPBELL

233 Leslie Campbell Avenue, P. O. Box 4260, Buies Creek, North Carolina 27506
Telephone: **(910)-814-5709** Fax: **(910) 984-1560**

REFERRAL FORM FOR FACULTY/STAFF

Student Name: _____ **Student ID:** _____

Student Phone Number: (H)_____ **(C)**_____

Faculty/Staff Name: _____ **Department:** _____

Faculty/Staff Phone Number: _____

Comments or concerns regarding the referral:

_____

_____

_____

This form verifies the referral of a student to Counseling Services by a faculty/staff member of Campbell University. Please read the following options and check all that apply:

Regarding initial contact with student:

- ❒ The student came to me regarding his or her situation.
- ❒ I contacted the student regarding my concerns for him or her.

Regarding the faculty/staff member's desired level of involvement:

- ❒ I want to refer the student for counseling services.
- ❒ I would like to know if the student accepted and acted on the suggestion to seek counseling with Counseling Services. ****** Please understand that Counseling Services cannot release confidential information about a student without his/her written authorization. This includes confirmation of student's attendance.******
- ❒ Other: _____

Regarding the student's contact with Counseling Services:

- ❒ The student will call or come by Counseling Services.
- ❒ The student wishes to be contacted by Counseling Services at the phone number listed above.
- ❒ Other: _____

_____ _____

Signature of Student **Date**

_____ _____

Signature of Campbell University Faculty/Staff **Date**

***Please note that this form **IS NOT** required for students to be seen or referred to Counseling Services. It is part of an effort to form a collaborative relationship between students, staff, faculty, and Counseling Services.

THIS FORM IS TO BE CAMPUS MAILED IN A SEALED ENVELOPE—MARKED CONFIDENTIAL—TO *COUNSELING SERVICES.*

Revised 1/11/2017