

Counseling Services @ Campbell University

95 Pope Street (House behind the Wallace Student Center)

P. O. Box 4260, Buies Creek, North Carolina 27506

Telephone: **(910)-814-5709/5708**

Fax: **(910) 814-5717**

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 the 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.**