2019-2020

University Counseling Center
206 Student Services Building
Grand Valley State University
1 Campus Drive
Allendale, MI 49401-9403

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www.gvsu.edu/counsel

Medical Referral Form

The purpose of this form is to exchange introductory referral information between the professional treatment staff at the GVSU University Counseling Center and community medical providers.

Date of Referral: _____ Date of Birth: _____

Client Name: _____ Legal Name *(if varied)*: _____

Gender: _____ Pronouns: _____

Permanent Address: _____

Reason for Referral: _____

_____

_____

Client Type:
- ☐ Client is currently participating in services at UCC
- ☐ Client has been referred to a community provider
- ☐ Client declined services at UCC, medication only

Release of Information completed ☐

Next University Counseling Center Appointment (Date/Time): _____

Risk assessment completed? ☐ Y ☐ N

* Results _____

Diagnosis: _____

Does client have insurance? ☐ Y ☐ N

Known medical Issues: _____

_____

Current medications: _____

_____

Family mental health history: _____

_____

_____
(Referring Counselor Signature) (Supervisor Signature) (Date)

_____
(Client: Print & Sign) (Date)