UNIVERSITY OF THE WEST INDIES AT MONA
COUNSELLING SERVICE, UNIVERSITY HEALTH CENTRE

REFERRAL TO COUNSELLORS/PSYCHIATRIST

Name of staff member making referral: .....

Department:.....

Contact telephone number: .....

Name of student being referred:.....

Student's ID #: .....

Date of referral: .....

Reason for referral: (where applicable, state any changes noted e.g. in behaviour, speech, dress)

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Signature .....

NB. Please be aware that although you have referred the student, we cannot discuss the issues he/she raises in a session without his/her written permission. As the person who made the referral however, we can if you request, inform as to whether or not the initial appointment was kept.