Wellesley College Stone Center Counseling Service
Psychiatry/Medication Referral Form

Name: _____

DOB: _____ Year/Class: _____
(If under 18, parental consent is required)

Residence/Address: _____

Phone/cell: _____

Counselor: _____
(Trainees/Interns/Postdoc to consult with supervisor prior to referral)

Supervisor: _____

Date Began Treatment: _____ Date of Referral: _____

No. of Sessions: _____ Next Scheduled Appointment: _____

Reason for Referral: (include relevant symptoms/behavior)

_____

_____

_____

_____

Degree of Urgency:

_____Urgent (needs to be seen immediately) _____ Not Urgent

Explain: _____

_____

_____

Current Medications: (name/dosage)

_____

_____

Other Relevant Information/History: _____

_____

_____

_____

Form completed by: _____
Name Title

Outside Therapist: _____
Address

_____
Phone # Email

Revised 12/12