PRE-REFERRAL FORM

Please complete form prior to meeting with Ms. Janelle Silbert, case manager, to aid in appropriate referrals during your case management appointment.

Student's Name _____

Phone Number_____ Date of Birth_____

Today's Date _____Case Management Appt: _____

Last Seen By (at the Counseling Center): _____

For ___triage appointment or___regular therapy

Health Insurance Information: Insurance Carrier _____

Health Insurance ID #: _____

___ I do not have health insurance

Phone number for behavioral health/mental health on the back of your insurance card (this may be the general number if not specified): _____

Do you give us permission to call about your health insurance benefits, eligibility, and in-network providers prior to your appointment? ____yes ___no

Please ask our staff copy your insurance card, if available.

If you don't have your health insurance information available right now, please email Ms. Silbert (jsilbert@wcupa.edu) with your health insurance carrier information as soon as possible.

Do you have your own transportation (e.g., own car)? ___ yes ___ no

Are you able to access and/or are you comfortable with public transportation? ___ yes ___ no

For which areas are you seeking a referral? Please check all that apply.

___West Chester ___North of West Chester ___South of West Chester

___Philadelphia ___other: please name _____

What are your issues for which you would be seeking a referral? Please check all that apply (list continues on next page):

___anxiety ___obsessions or compulsions ___perfectionism ___stress

___depression ___mood instability ___anger management

___relational problem ___family issues ___grief/loss

___health/medical ___eating/body image ___sexual concern

___sexual orientation ___gender identity ___career/academic concerns

___alcohol ___ drugs and pills ___addiction

___self-injury ___suicidal thoughts or behavior ___disturbing thoughts

___trauma ___desire to hurt others ___physical abuse/assault

___legal issues ___harassment/emotional abuse ___sexual abuse/assault

___other: please describe: _____

Do you have a preference in gender of provider? ___no preference ___female ___male

Do you have a preference for ethnicity/cultural considerations of provider? Please describe: _____

_____

Have you been in therapy before? _____Yes _____No

What did you like/dislike about it?_____

_____

Do you need a referral to any of the following? Please check all that apply:

___psychiatrist ___dietician/nutritionist ___drug and alcohol counselor

___Other: please describe:

_____