

**Wellesley College Stone Center Counseling Service
Psychiatrist Referral Form**

Name: _____

DOB: _____ **Year/Class** _____

(If under 18, parental consent is indicated.)

Residence: _____

Phone/cell/voice mail: _____

Counselor: _____

Supervisor: _____

(Trainees/Postdoc. to consult with supervisor prior to referral)

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: _____

_____ **College Insurance** **Is it okay to use insurance?** ___ **Yes** ___ **No**

_____ **Other Insurance** _____

(list name, policy number, and phone number)

Other Relevant Information: _____

Form completed by: _____

Title: _____