# Referral for On-Campus Psychiatric Services from Off-Campus Provider

Please complete **only** the **top portion** (to be completed by referring psychologist/therapist/psychiatrist/primary care)

| Student name & UCSC I.D. #: | D.O.B:<br>☐ M ☐ F ☐ Transgender | Student Phone #:<br>Message okay? Y N |
|---|---|---|
| Date of Referral: | Name of Referrer: | Phone #:<br>Fax #: |

Consent to Release Information signed by student? Y ☐ N ☐

Diagnosis: _____

Reason for referral: _____

_____

1. Is student currently on medication? Y ☐ N ☐ 2. Is student interested in medication? Y ☐ N ☐

If yes (to Q1): Medication(s): _____ Length of Time on Medication: _____

Prescriber: _____

Follow-up Plan: _____

3. Is student in on-going psychotherapy with you? Y ☐ N ☐

If yes: Length of Time/ Number of Visits: _____ Date of Next Appt: _____

Follow-up plan:_____

**BOTTOM PORTION TO BE COMPLETED BY ON-CAMPUS PROVIDERS ONLY**

| **Psychiatry Desk:** Received Date/Initials_____<br>Contact With Student Notes/Dates: | App't Date/Time/Dr:<br>Alternative Arrangement:<br>☐ Off-campus Psychiatrist/Primary Care Provider<br>☐ SHC Physician ☐ Other _____ |
|---|---|

**To be completed by Psychiatrist (Check all that are appropriate):**

☐ Evaluated; no ongoing psychiatric care indicated
☐ Continue to see on-campus Psychiatrist provider
☐ Referral to Health Center Physician
☐ Other _____
☐ Refer back to off-campus therapist
☐ Refer back to off-campus psychiatrist/primary care
☐ Did not come to initial evaluation
☐ Never made appointment

**Brief Evaluation:**

**Psychiatrist:**

**Please fax this completed form with the Release of Information to Counseling and Psychological Services at (831) 459-5116. If you have any questions, please call (831) 459-2628. Please retain a copy of this referral for your records.**