Intake Scheduled Date: _____

Time of Intake: _____

Location: _____

Therapist: _____

Mental Health Counselors on Campus

Referral Form

Client Name: _____ Age:_____ Grade: _____

Parent/Guardian Name:_____

Parent/Guardian Phone: (H) _____ (W)_____ (C)_____

Leave Message? Yes ☐ No ☐

Parent/Guardian Email:_____ Student's Email:_____

Seeking Counseling for Child at (Name of School): _____

Referring Professional School Counselor: _____

Tell us how you heard about MHCOC: _____

Reason client may be in need of counseling:_____

_____

_____

_____

☐ Advised client of clinic policy: **Session may include a supervisor for training purposes. Counselors are supervised and the session may or may not be videotaped.**

We do not provide any information or verification of services for court proceedings of any kind as outlined in our contract for therapy. Tapes of sessions are for training only and are not provided to parent(s)/guardian.

PROFESSIONAL SCHOOL COUNSELOR'S STATEMENT OF RESPONSBILITY:

By endorsing this box, I am affirming that I have contacted the parent/guardian to inform them that they will be receiving information from the University of Mississippi Mental Health Counselors on Campus program. ☐