Referral Form

Lane Community College
ACHIEVING DREAMS
Counseling Department

Referral To: ☐Counselor ☐Intern ☐ Either	**Date:**
Student Name: (Must be current student)	**L#** **Age:**
Address:	**Major:**
Phone(s):	**OK to leave a message?** **☐ Yes ☐ No**
Email Address:	**OK to leave a message?** **☐ Yes ☐ No**
Days/Hours of Availability:	**Does student have Health insurance that covers mental health?** **☐ Yes ☐ No**
Prior Counseling experience? ☐ Yes ☐ No **If so, when?**	
Presenting Problem(s): *Note – To benefit recipient be as detailed as possible* **Goals of Counseling:**	
Suicide Risk? ☐ Yes ☐ No **If "Yes," please discuss in detail.**	
Referring Counselor/Advisor:	**Extension:**

Lane Community College Counseling Department, 4000 E. 30th Ave., Eugene OR 97405-6040
Main(541) 463-3200 *Fax*(541) 463-4166 http://www.lanecc.edu/stuser/coundept.htm
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