

Andrews  University  
Counseling and Testing Center

**CONFIDENTIAL VOLUNTARY REFERRAL**

Name of Student \_\_\_\_\_ AU ID# \_\_\_\_\_ Phone # \_\_\_\_\_

Referred by: USIT  Division of Student Life  Dean  Faculty  Staff

Referring Professional: \_\_\_\_\_ Phone# \_\_\_\_\_  
First Name Last Name

Title: \_\_\_\_\_ Department: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Briefly state reason for referral: (Please include any known medical or other conditions relevant to this referral) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(Please attach to this document any additional information)*

---

---

**This referral is for** *(Check all that Apply):*

*University Counseling & Testing Center:*

- Psychotherapy/Counseling
- Substance Use Psychoeducational Sessions (6)
- Psychological Assessment
- Substance Abuse Assessment
- Career Assessment
- Intellectual/Achievement Assessment
- Other (Please Specify): \_\_\_\_\_

*University Medical Services:*

- Drug Testing
- Physical Exam
- Other (Please Specify): \_\_\_\_\_

**To maintain confidentiality please use a sealed envelope marked  
"CONFIDENTIAL."**

**CONSENT FORM  
OF  
RELEASE OF CONFIDENTIAL INFORMATION**

**Optional:**

The above named student has explored with me his/her need for counseling, understands the benefits of counseling, and is open to engaging in a psychotherapeutic experience.

TO BE COMPLETED BY STUDENT

**Purpose: To help me develop skills needed to succeed at Andrews University and beyond**

I, \_\_\_\_\_ (Student Name), **authorize Andrews University:**

**Circle One:** Counseling & Testing Center / Medical Specialties / Faculty/Staff

Other: \_\_\_\_\_

**To disclose to referring Faculty/Staff/Department/USIT, the following information, by written or verbal communication:**

Attendance to appointments

I understand that my records are protected under the code of Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this consent expires automatically as described below.

**Date, event, or condition upon which this consent expires:**

**End of school year**

**End of semester**

**Other:** \_\_\_\_\_

**Student:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Signature

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Print

**Witness Signature:** \_\_\_\_\_