University of Redlands Referral for CCS Mental Health Services

email completed Referral Form to intake@ccs-cares.org

Referred By:
❑Self ❑Staff:____

Brief Release Required: ❑Yes ❑No   Full Release Required: ❑Yes ❑No

Client Information:

Name:________________________________ DoB:________________

Email:________________________________ Phone:_______________

Address or Dorm Information:____________________________________

Education Level:__________ Gender Identity: ________ Preferred Pronoun: _______

Primary Language:__________________

Insurance Information

Insurance Carrier: ___________________________ State:__________

Policy Number: ___________________________

Group Number: ___________________________

Subscriber Name : ________________________Subscriber DOB:_________

Reason(s) for Referral: *Check all that apply*

❑Academic Concerns
❑Anger Outbursts
❑Anxiety
❑Bullying/Victim of Bullying
❑Depressed Mood
❑Drug/Alcohol Use
❑Family Concerns
❑Feelings of Hopelessness
❑Grief/Loss

❑Harm to Others
❑Harm to Self
❑History of Child Abuse/Neglect
❑Hospitalization (Psychiatric)
❑Learning Disability
❑Online Harrassment
❑Parental Divorce

❑Property Damage
❑Sexual Assault
❑Suicide Risk
❑Trauma
❑Witness/Victim to Crime
❑Witness/Victim to Domestic Violence

❑Other: ________________________________

Services Requested at: ❑CCS ❑UoR Campus ❑Telemental Health/Phone