EAC Counseling Department
(800) 678-8426 - Toll Free
(928) 428-8253

Counseling Referral

Date: _____

Time: ___ : ___ ☐ **AM** ☐ **PM**

Name: _____
Name of Person Being Referred

Reason for the Referral:

Please describe the situation and your concerns (i.e. behaviors you have observed).

Indicate the seriousness of the situation on a scale from 1 to 10 with 1 being the least concerned and 10 being the most.

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

(Please check one)

Follow-Up Request: (Please check one)
☐ IMMEDIATE (NOW)
☐ URGENT (SAME DAY)
☐ ROUTINE (THIS WEEK)

Referral Source Name: _____
Name of Person Making Referral

Department: _____

Phone: ( ) _____

Date Needing to be Seen: _____
Request an Appointment