

Referral for health and safety assessment

Out of concern for your health and safety, and that of your community, University Residences is referring you to the Counseling Center for a health and safety assessment. Please read the following information and sign below to indicate that you understand and will follow through on this referral.

Date of incident: _____ IR or UP report # _____

I, **NAME**, understand that:

1. By **DATE** I will contact the Counseling Center at 360-650-3164 and ask to speak with Counselor Phil Burns, Eric Denson, or their designee to set up a health and safety assessment. (*Please specify when you call that you have been referred by Residence Life for a health and safety assessment.*) The counselor/psychologist who performs this assessment is acting as a consultant to Residence Life, and is not my personal health care provider. I will comply with any recommendations for ongoing counseling and provide documentation for doing so. The Counseling Center is located in Old Main 540.
2. If I am very depressed or have a strong desire to hurt myself I will contact the Counseling Center at 360-650-3164. If I feel that I am in imminent danger of hurting myself, or have a strong desire to hurt myself when Counseling Center staff are not available, I agree to contact University Police at 360-650-3911. If I'm off-campus, I will call 911.
3. If I do not complete this referral, it will likely result in action by University Residences. If I have questions or concerns about this referral, I may contact **RD NAME** at _____
4. My RD or someone from the Suicide Intervention Team will talk with me after I complete this referral, which might also include developing a Commitment to Safety and Treatment.
5. I authorize release of information to Residence Life staff, from the WWU Counseling Center, regarding confirmation of whether or not I schedule and attend this assessment at the Counseling Center. I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this Authorization to release information expires after 90 days of the signature.
6. I will also sign release forms with Counseling Center staff that allows them to share information with University Residences professional staff about meeting the above conditions and recommendations. I understand personal information about me unrelated to recommendations will not be shared.

NAME

Date

RD

Date

cc: Counseling Center
Suicide Intervention Team