Student Health Center
University of Missouri Health

University of Missouri
CONSULT/REFERRAL FORM

Patient Name_____

Student ID#_____

Home Phone_____

Cell Phone_____

TO: **Specialty/Service ADHD/LD Testing/Assessment**

FROM: MU Student Health Center Date: _____

Tentative Diagnosis & Pertinent Clinical Data:

_____

_____

_____

REFERRAL REQUEST

_____
Provider Signature

_____Confirm Diagnosis
_____ Suggest treatment and academic accommodations
_____ Please fax written report to 573-884-1811

Student Health Center
University of Missouri
1020 Hitt St.
Columbia, MO 65212
(573) 882-1483 Behavioral Health
(573)882-7481 Primary Care

ATTACHMENTS

____ Release of Information

____ Referral Form faxed to **573-884-3399**__ on _____
(fax #) (date)

____ Copy in Chart

____ Copy to Behavioral Health

consref.frm. 05/16 pr