Referral to Thomas E. Cook Counseling Center at Virginia Tech

Please see the below request for services at Thomas E. Cook Counseling Center. Please note that referrals should not be sent for individuals in acute crisis that require inpatient admission or crisis stabilization. Thomas E. Cook Counseling Center does not assume treatment for individuals referred until intake assessment.

Fax completed form to: 540-231-2104

Name of Provider and Agency requesting referral: _____

Phone Number of Provider and Agency: _____

Address of Provider and Agency: _____

Re: Full name and pronouns of Individual being referred: _____

Phone Number **and** VT Email Address of Individual being referred: _____

Virginia Tech Student ID Number of Individual being referred: _____

Date of Birth: _____

Please indicate what type of services you are providing for the individual you are referring:

- o Individual Counseling
- o Group Counseling
- o Assessment
- o Psychiatry
- o Primary Care
- o Other _____

Type of Service requested from Cook Counseling Center:

- o Individual Counseling (typically every 2-3 weeks)
- o Group Counseling
- o Psychiatry

In order for us to process this request, please include a <u>Release of Information</u> and a <u>treatment summary</u> with this form. Forms received without a Release or Treatment Summary will not be processed.

By signing this form, I confirm that I have discussed this referral with the individual above and they have agreed for Thomas E. Cook Counseling Center to contact them to discuss the referral.

If you have urgent concerns related to this referral, please contact Thomas E. Cook Counseling Center at 540-231-6557 and ask to speak with the psychiatry nurse for psychiatry referrals or the Assistant Director for Clinical Services for counseling referrals

Signature of Provider: _____

Date of Referral: _____

Internal processing information

Date Referral was received: _____ Received by: _____

Responded to by (provider name and date): _____

- o Contacted the Referral source
- o Contacted the Individual Referred

Thomas E. Cook Counseling Center Virginia Tech
Main number: 540-231-6557
Fax: 540-231-2104

Locations:
2475 Oak Lane – main office and crisis location
East. Eggleston Hall, Rm 107
202 S. Main St. Kent Sq
300 Turner St. NW, Suite 4500

All currently enrolled Virginia Tech undergraduate and graduate student who have paid the Student Health Fee are eligible for services at Cook Counseling Center. Spouses / partners (who are not enrolled VT students), other family members, faculty, staff, or alumni are not eligible. Students are not eligible in the semesters following medical withdrawal (academic relief) or in semesters that they are away from VT on academic or disciplinary suspension.

Cook Counseling Center has expanded our services and options to allow for a flexible, multi-faceted approach to meet the emerging and varying needs of students.

The **Cook Connect Model** is designed to provide students with tailored planning, more support options, and faster response. We have designed our services so that students can be seen as quickly as possible to discuss what is going on and what services inside and outside of Cook can help holistically address their needs.

Students begin by calling to schedule a **Cook Connect Session.**

- At this brief appointment, the clinician will listen for student concerns, discuss available resources, and collaboratively develop recommendations that provide support. Clinicians will also discuss how students can follow up or return if needed.
- **Services at Cook:** campus outreach and prevention education, support groups and workshops, referrals to off campus providers or campus offices, brief and focused individual therapy, group therapy, and psychiatric services.
    - *As a counseling center in a university setting, service availability often depends on the time of the semester. Groups typically close after filling by mid-semester and individual services may pause prior to or during semester breaks.*

Community providers can refer students to Cook Connect for therapy or psychiatric services.

- Off campus providers should send the **Thomas E. Cook Counseling Center Referral Form**, a **Release of Information** and a **Treatment Summary** to (FAX) 540-231-2104.
- Psychiatry referrals for ADHD medication require full educational testing *prior to referral.*
- Cook Counseling Center will respond to referral requests by attempting to contact the individual referred two times. The referring provider will be notified of the outcome of the referral.

Specialized services including but not limited to: Emotional Support Animal letters, ADHD testing, disability or military evaluations, weekly or long-term individual therapy or intensive outpatient services are outside the scope of Cook Counseling Center. Cook providers will assist with connection to these resources.

Crisis support is always available by calling the main number: 540-231-6557 or by calling ACCESS at 540-961-8400

THOMAS E. COOK COUNSELING CENTER
2475 OAK LANE, VIRGINIA TECH
BLACKSBURG, VA 24061-0108
PHONE (540) 231-6557
FAX (540) 231-2104

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ do hereby request that the Thomas E. Cook Counseling Center of Virginia
Name (Print)
Tech engage in the following as it relates to my records.

In accordance with this request, I hereby release and forever discharge and agree to hold harmless and indemnify the Commonwealth of Virginia, Virginia Tech, the Thomas E. Cook Counseling Center administration and staff, and all other officers, agents and employees of the University from any and all claims, demands, damages, actions or suits of law or in equity of whatever kind which might arise in accordance with my request.

Purpose of Disclosure:

____Continued care
____Employment
____Legal
____Personal knowledge
____Insurance
____Other_____

Additional information about purpose of disclosure:

_____

Check all desired:

_____Please have the following information **from** an outside person/provider/agency conveyed to the Thomas E. Cook Counseling Center.
_____Please have the Thomas E. Cook Counseling Center convey the following information **to** an outside person/provider/agency (allow 2 weeks to process).

COUNSELING RECORDS

_____Treatment summary
_____Diagnosis
_____Treatment recommendations
_____Dates of treatment
_____Testing results
_____Other_____
_____Exclusions (items not to be disclosed) _____

PSYCHIATRY/MEDICAL RECORDS

_____Initial evaluation
_____Progress notes
_____Last clinical visit note
_____Lab results
_____Diagnosis
_____Dates of treatment
_____Other_____

How would you like this information communicated?

____Verbal discussion
____Written information
____Other_____

_____

Outside person/provider/title

_____

Name of agency/affiliation/relationship

_____

Mailing address: street, city, and zip code

_____

Phone and fax number

I understand this authorization is voluntary and not a condition of treatment. This authorization is automatically void after 1 year, and may be terminated by me at any time with a written notice, effective as of the date of signature. Information sent and/or received through this authorization may not be re-released to another individual or agency.

I may revoke authorization at any time, but my revocation is not effective until delivered in writing to the Cook Counseling Center and is not effective as to health records already disclosed under this authorization. A copy of this authorization and notation concerning the persons or agencies to which disclosure was made will also be included with my original health records.

I understand that although Cook Counseling Center is not a covered entity as pertains to HIPAA regulations, the counseling center respects and restricts access to records for my confidentiality.

I understand Cook Counseling Center cannot respond to background checks or security clearance questionnaires which require assessment and/or prediction of behaviors regarding a person's fitness to safeguard national security information. We will, however, provide dates of treatment, diagnoses, and presenting concerns at Cook Counseling Center.

I understand that Cook Counseling Center recommends a treatment summary for third party requests (non-health care providers). You are entitled to request your health records and if you choose to share your records with third party individuals (non-health care providers) there may be risks to how clinical information is interpreted and used to make decisions on my behalf.

I understand that I may ask to see copies of my health record as well as information about any disclosures that were made.

_____***Please initial to indicate you understand that the release of your records may include information related to substance use which is protected by Federal Regulations (42 CRF Part 2) and requires specific written authorization for such disclosure. Federal Regulations restrict use of any disclosure from being used in criminal investigations.***

_____	_____
Name of student (print)	Phone number of student
_____	_____
Signature of student	Date
_____	_____/_____/_____
Student identification number	Date of birth
_____	_____
CCC staff witness	Date

office use only scan only: ☐ sent records: ☐ requested records: ☐

Information released:_____

Signature: _____ Date:_____