Tobacco & Vaping Treatment
REFERRAL FORM

Please complete the below information to refer a student to the tobacco and vaping intervention program.

STUDENT NAME	
DATE OF REFERRAL	
REFERRER INFORMATION (NAME/ROLE)	
REASON FOR REFERRAL	☐ REQUIRED/POLICY VIOLATION ☐ VOLUNTARY ☐ OTHER:
ADDITIONAL REFERRAL INFORMATION	

For treatment appointment scheduling submit form to: