LEARNING CENTER REFERRAL FORM

Clinical Instructor to complete section A

Student: ______________________________________ Program: ________________________________
Email: ______________________________________ Contact Phone #: __________________________
Referred by: __________________________________ Course: _________________________________
Date of referral: ____________________________ Date to be completed: ______________________
Reason for referral:
☐ Absent
☐ Remediation*
☐ Practicum Redo*
☐ Extra Practice

Skill to Perform:__________________________________________________________________________

Specific Skill(s) for Referral:_____________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Prescription for completing this Referral:
☐ Review skill in Potter & Perry textbook
☐ Review skill in Lewis textbook
☐ Review skill in on Virtual IV
☐ Review Medications in Kee Pharmacology textbook
☐ View Skills Video on DVD
☐ Mandatory/Makeup Hours in HSLC ______
☐ Practice skill 5 times with peer
☐ Practice skill 5 times with an upperclassman
☐ Practice skill with instructor
☐ Other ____________________________________________

To make an appointment the student should:
✓ Fill out times of availability on back
✓ Give referral to the skills lab coordinator immediately after skill performance
✓ Complete Self-evaluation form (*if remediation or practicum redo is needed)
✓ Be contacted and confirmation will be made by PirateMail and/or phone

Contact the HSCLC at 471-4510 if you cannot keep your appointment

Learning Center Instructor to complete section B

Appointment for Evaluation: ________________________ Instructor: ___________________________
Evaluation: ____________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

The prescribed activities: _____ have been successfully completed.

_____ have not been successfully completed.

Signature of Evaluator: ______________________________ Date: _______________________

HSLC rev 12/4/12
## Times available for referral *(Student to Complete)*

<table>
<thead>
<tr>
<th>Day Available</th>
<th>From Time:</th>
<th>To Time:</th>
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## Log of Time in Health Science Resource Center *(Lab to Complete)*

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<tr>
<th>Date</th>
<th>Skill/Tasks Performed</th>
<th>HSLC Time In</th>
<th>HSLC Time Out</th>
<th>Signature of HSLC Coordinator or Clinical Instructor</th>
<th>Total Time Claimed</th>
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