

**Xavier University of Louisiana**



**Office of Disability Services  
Referral Form**

**Date** \_\_\_\_\_

**Student's Name** \_\_\_\_\_

**Classification** \_\_\_\_\_ **Major** \_\_\_\_\_

**Referred by:** \_\_\_\_\_

**Dept.** \_\_\_\_\_ **Campus Ext.** \_\_\_\_\_

**Reason for referral:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Referring Person's Signature**

**Date**

\_\_\_\_\_

**Send form to: Office of Disability Services    Box D or  
Fax form to: (504)-520-7943**