**SAUK COUNTY DEPARTMENT OF HUMAN SERVICES**

PO BOX 29 \* BARABOO, WI 53913

(608) 355-4200 \* FAX (608) 355-4299

**Integrated Services Program (ISP)**

*Comprehensive Community Services and Families Come First*

**Universal Referral Template**

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| **Today’s Date:**       | **Referrer’s Name:**      | **Referrer’s Phone #:**      |
| **Referrer’s Organization:**       | **Referrer’s Email:**      |
| **Services to be provided to:**  | **[ ]  Consumer [ ]  Parent/Guardian [ ]  Sibling** | **Name:** |       |
|  |
| **CONSUMER DEMOGRAPHIC INFORMATION** |
| **First Name:**      | **M.I.:**     | **Last Name:**      | **Pronoun Preference:**      | **Date of Birth:**      | **Age:**   |
| **Main Contact Phone:**      | **Email:**      | **Primary Language:**       | **Current School:**       | **Grade:**      |
| **Physical Address:**      | **City:**      | **State:**   | **Zip:**      |
| **Mailing Address *(If Different Than Physical)*:**      | **City:**      | **State:**   | **Zip:**      |

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| **PARENT/GUARDIAN INFORMATION** |
| **First Name:**      | **M.I.:**       | **Last Name:**      |
| **Relationship:**       | **Primary Language:**      | **Primary Phone:**      | **Email:**      |
| **Is this person currently living with consumer? [ ]** Yes **[ ]** No If no, please provide address below:  |
| **Address:**      | **City:**      | **State:**   | **Zip:**      |
|  |
| **First Name:**      | **M.I.:**       | **Last Name:**      |
| **Relationship:**       | **Primary Language:**      | **Primary Phone:**      | **Email:**      |
| **Is this person currently living with consumer? [ ]** Yes **[ ]** No If no, please provide address below:  |
| **Address:**      | **City:**      | **State:**   | **Zip:**      |

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| **CONSUMER’S TREATMENT GOALS:** |
| **Goal #1:** |       |
| **Goal #2:** |       |

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| **PRESENTING NEEDS AND DIAGNOSES** |
|       |

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| **STRENGTHS/HOBBIES/INTERESTS/TALENTS/SKILLS** |
|       |

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| **SERVICES/PROVIDERS DESIRED** |
| **[ ]  Diagnostic or Specialized Evaluations** | **[ ]  Group Therapy** |
| **[ ]  Family Therapy** | **[ ]  Individual Psychotherapy *(Please Select Type)*** |
| **[ ]  Individual Skill Development**  |  | **[ ]  Mental Health** |
| **[ ]  Psychoeducation** |  | **[ ]  Substance Use** |
| **[ ]  Screening & Assessment/ASAM** |  | **[ ]  Dual** |
| **[ ]  Health Monitoring** | **[ ]  Recovery Education/Wellness Management** |
| **[ ]  Medication Management** | **[ ]  Other:** |       |
| **[ ]  Employment Skills Training** |  |

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| **AVAILIBILITY/PREFERENCES** *(Please Check All That Apply)* |
| **[ ]  Monday** | **[ ]  Tuesday** | **[ ]  Wednesday** | **[ ]  Thursday** | **[ ]  Friday** |
|  | **[ ]  Morning** |  | **[ ]  Morning** |  | **[ ]  Morning** |  | **[ ]  Morning** |  | **[ ]  Morning** |
|  | **[ ]  Afternoon** |  | **[ ]  Afternoon** |  | **[ ]  Afternoon** |  | **[ ]  Afternoon** |  | **[ ]  Afternoon** |
|  | **[ ]  Evening** |  | **[ ]  Evening** |  | **[ ]  Evening** |  | **[ ]  Evening** |  | **[ ]  Evening** |
| **Preference(s):** | **[ ]  Community** | **[ ]  Home** | **[ ]  Office** | **[ ]  Telehealth** | **[ ]  No Preference** |

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| **PROVIDER PREFERENCES**  |
| **Provider Type:**  | **[ ]** Bachelors  | **[ ]** Masters  |
|  | **[ ]** Nurse | **[ ]** Occupational Therapist |
|  | **[ ]** Psychologist  | **[ ]** Rehabilitative Worker |
|  | **[ ]** Other:  |       |
| **Specific Provider Requested:** |       | **Provider Gender Requested:** |       |
| **LGBTQI+ Friendly:** | **[ ]** Yes **[ ]** No Preference  | **Treatment Modality:** |       |
| **Other:** |       |

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| **OTHER IMPORTANT INFORMATION**  |
| *(Cultural Factors, Scheduling, Health Issues, Court Orders, Transportation, etc.)* |
|       |