**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.)* |
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