

*Comprehensive Community Services*

**Referral From**

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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:** |   |
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| **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: Reedsburg**   | **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:** I | **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 - Trauma** |
| **☐ Psychoeducation** |  | **☐ Substance Use** |
| **☐ Screening & Assessment/ASAM** |  | **☐ Dual** |
| **☐ Health Monitoring** | **☐ Recovery Education/Wellness Management** |
| **☐ Medication Management** | **☐ Other:** |       |
| **☐ Employment Skills Training** |  |

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| **AVAILABILITY/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:** |   No Pref  |
| **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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