|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Phone:** |  |
| **DOB:** |  | | |
| **Address:** |  | | |
| **Name of Referrer:** |  | | |
| **Date of Referral:** |  | | |

**Does consumer have Medicaid (MA, Badgercare, etc):**  Yes  No

**Type of Referral: (all that apply)**

Mental Health Substance Abuse

**Please list diagnoses, if known:**

**Past or Current Services (check all that apply)**

|  |  |
| --- | --- |
| MH Counseling/Therapy | Substance Abuse Counseling |
| AA or NA Meetings | Probation |
| Inclusa/IRIS | IEP (if student) |
| Psychiatric Hospitalization | Inpatient Substance Abuse Treatment |
| Psychiatry/med management | Involvement with CPS (Current) |
| Drug Court | Under Guardianship (adult only) |
| Other: | |

**Please include any information that may be useful to better understand the needs of the consumer. Note any known goals for the consumer:**