|  |  |  |  |
| --- | --- | --- | --- |
| **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:**