ASHLAND COUNTY
COMMUNITY SERVICE PROGRAMS

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Terry Barningham, Director

Community Service Programs
Referral Form

Referral Date:

Name: ________________________________ **Date of Birth:** _____________________

Gender: ☐ **Male** ☐ **Female** ☐ **Other/Non-binary** **SSN:** ____________________________

Address: ____

City: ____ **State:** ______________ **Zip:** _________

Phone: ______________________ **Cell:** _________________ **Work:** ____________________

Referring Person: ________________________**Contact Information:** _______________________

Current Programs: IRIS_______ **Inclusa**________ **Wellness Court:** __________

Commitment or Settlement Agreement? ______ **Yes** _______ **No**

If this is a child under 18, please obtain the following information:

#1 Parent/Guardian: ______________________________ Relationship: _____________________
Address (if different than above) ____
Phone: ___________________ Cell: ___________________ Work: ______________________________

#2 Parent/Guardian: ______________________________ Relationship: _____________________
Address (if different than above) ____
Phone: ___________________ Cell: ___________________ Work: _____________________________

WI Medicaid ☐ Yes ☐ No MA Number: ____________________________________
*Please have a copy of your Forward Health card at time of admission.

Other Insurance: ____

Are you receiving treatment for a mental illness or substance use? ☐ Yes ☐ No

If not, would you like help with addressing issues of mental illness or substance use? ☐ Yes ☐ No

How does your experience of mental illness or substance use interfere with your daily functioning?

What are the most important issues that this program can help you address?
1.

2.

3.

Who is your physician and/or psychiatrist? ____

Any Recent Hospitalizations:
Date___________________ Place___________________________________
Reason____

Date___________________ Place___________________________________
Reason____

Date___________________ Place___________________________________
Reason____

In order to move forward with these services, you must sign a Release of Information (ROI) so that medical records can be acquired from your physician/psychiatrist. What would be the best or easiest way to accomplish this? In-person or by mailing a Release of Information form?

In-person & Date Completed ______________________ Date Mailed _______________________

How did you hear about the Community Support Programs?

- ☐ **Self** ☐ **CSP/CCS**
- ☐ **School ____**
- ☐ **Ashland County** ☐ **Bayfield County**
- ☐ **Other ____**

Staff Signature: ____ Date: ______________

Service Director/Clinical Coordinator (or designee) Review:

I have reviewed this initial referral and believe that this person would benefit from further screening for psychosocial rehabilitation services.

Service Director/Clinical Coordinator: __________________________________ Date: ______________