Shawano County Department of Human Services
External Referral Form

Referral For: ☐ Outpatient- MH ☐ Outpatient- AOD/SUD ☐ Community Mental Health/Case Management

Referral: ☐ Sent email/fax ☐ Obtained via phone, by: _____

****** All asterisked information is required to process referral ******

Referral Source:

*Agency Name: _____ *Date: _____

*Staff/Provider Name: _____ * Direct phone #:_____

Fax number: _____ Email address: _____

*Is the client aware of the referral? ☐ Yes ☐ No *Release of information included? ☐ Yes ☐ No

*Are these services court ordered? ☐ No ☐ Yes, select one: ☐Child Protection ☐Youth Justice ☐Probation ☐Crisis

Client name Demographics:

*Name (Last, First, MI):_____

*D.O.B.: _____ Age: _____ Sex: ☐ Female ☐ Male ☐ Other SSN:_____

*Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Biracial ☐ Caucasian

☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ ☐ Declined to specify

*Ethnicity: ☐ Hispanic ☐ Not Hispanic/Latino ☐ Declined to specify *Primary language is English ☐ Yes ☐ No

Education: ☐ Current grade: _____ ☐ HSED/GED ☐ Some College ☐ Bachelors ☐ Advanced Degree ☐ UNK

Employment Status: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Disabled ☐ Unemployed ☐ Other/Unknown

*Marital Status: ☐ Single/Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

*Is the client deaf/hard of hearing? ☐ Yes ☐ No Current or previous military service member? ☐ No ☐ Yes

*Does this client have a guardian or power of attorney? ☐ No ☐ Yes, name/relationship:_____

*If parents are separated/divorced, please identify current custody status: ☐ Joint ☐ Sole

*Address (Street, City, Zip) _____

_____

*In Shawano County? ☐ Yes ☐ No Living Arrangement: ☐ Home/Apt. ☐ Homeless/Shelter ☐ Correctional Facility

*Home/Cell #:_____ Email Address: _____

Medical History/Information

*Primary Care Doctor: _____ *Clinic_____ Date last seen: _____

Identify any current medical condition(s) and current medication(s) *or attach most recent medical progress note*:

_____

_____

*Enrolled in Family Care? ☐ No ☐ Yes, please select which MCO: ☐ Lakeland Care ☐ Inclusa ☐ IRIS ☐ Unknown

*Income source: ☐ Employed ☐ SSI/SSDI ☐ VA benefits ☐ Family ☐ None ☐ Unknown

*Insurance Provider: _____

*Does the client have a current therapist? ☐ No ☐ Yes: _____

*Does the client have a current psychiatrist? ☐ No ☐ Yes: _____

***Please identify reason(s) you are referring for services, check all that apply:**

- ☐ Alcohol/Substance Abuse
- ☐ Anger/rage
- ☐ Anxiety/Worry/Fear
- ☐ Behavioral issues
- ☐ Communication Problems
- ☐ Depressed Mood
- ☐ Emotional abuse
- ☐ Family conflict
- ☐ Gambling
- ☐ General stress
- ☐ Grief/loss/mourning
- ☐ Hospital follow up
- ☐ Impulse control difficulties
- ☐ Intimate partner violence
- ☐ Learning/memory problems
- ☐ Legal issues
- ☐ Marriage/divorce issues
- ☐ Medication issues
- ☐ Nightmares/Phobia
- ☐ Obsessive thoughts
- ☐ Overeating or restricting food
- ☐ Panic attacks
- ☐ Parent/Child conflict
- ☐ Parenting
- ☐ Physical Abuse/Neglect
- ☐ Physical health problems
- ☐ Pre-marital counseling
- ☐ Problems with peers
- ☐ Sex Addiction/Pornography use
- ☐ Sexual abuse/assault
- ☐ Sexual Orientation
- ☐ Sleep issues
- ☐ Social Isolation/social issue
- ☐ Struggles at work/school
- ☐ Suicidal thoughts/self-harm
- ☐ Thoughts of harming others
- ☐ Trauma
- ☐ Other, describe:

***Select all risk factors that apply**

- ☐ Abuse/Neglect/Exploitation
- ☐ Co-morbid untreated or unstable medical condition(s)
- ☐ Current or recent alcohol/drug use
- ☐ Current or recent out of home placement
- ☐ Current or recent suicidal thoughts
- ☐ Current or recent thoughts to harm others
- ☐ Expelled or not attending school
- ☐ History of violence or aggression
- ☐ Homeless
- ☐ Intoxication/Withdrawal potential
- ☐ Pending criminal charges
- ☐ Recent arrest/jail stay or prison release
- ☐ Recent psychiatric hospital referral/admission
- ☐ Significant loss (ie. Employment, housing, relationship, death, etc.)

Please provide any additional pertinent information in the space below:

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Following the acceptance of this referral, a screening will be completed via phone with the prospective client to further assess current clinical needs.