Manitowoc County Human Services Department

REFERRAL FOR CHILDREN SERVICES

Check Program Referring to:

☐(CLTS) Children's Long Term Support ☐(CST) Coordinated Services Team

☐(CCS) Comprehensive Community Services ☐Outpatient Psychotherapy ☐AODA Counseling

Date of Referral: Referral Source Name:

Referral Source Address:

Referral Source Phone Number:

Child's Name

Name:		DOB:	
Address:		Age:	
City/State:		Sex: ☐M ☐F	
Telephone:		Social Security:	

Mother's Information		Father's Information	
Name:		Name:	
DOB:		DOB:	
Address:		Address:	
Phone:		Phone:	

Other Children in Home:

Name:		DOB:	
Name:		DOB:	
Name:		DOB:	
Name:		DOB:	

Type of Disability:

☐Developmental ☐Physical ☐Autism ☐Medical ☐Mental Health

*If physical disability, developmental disability, or autism, refer to CLTS

*If only mental health, refer to CCS

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Diagnosis:

Who Diagnosed/When?

Reason for Call/Referral:

Current Medications:

Current Services:

School: _____ Grade: _____ IEP: ☐YES ☐NO
History of suspension or expulsion: ☐YES ☐NO

Pediatrician:

Psychiatrist:

Therapist:

Other:

Community Outreach Worker:

Medical Assistance (MA): ☐YES ☐ NO Private Insurance: ☐YES ☐NO

☐Katie Beckett ☐SSI

Behavioral Concerns:
☐Suicidal statements ☐Destruction of Property ☐Physical Aggression ☐Self Harm
☐Running away ☐Tantrums/meltdowns ☐Defiance ☐Suicide attempts

☐Sexual acting out ☐Homicidal statements ☐Bullying
☐Other _____

Known Medical Conditions: _____
_____

Drug/Alcohol Information:
☐Currently using tobacco.
☐Currently using alcohol.
☐Currently using Marijuana
☐Currently using other _____

☐Juvenile Justice Involvement
☐Child Protective Services Involvement

For CST please check all that apply:
☐Use of multiple direct services (e.g. mental health, special education, juvenile justice, CPS)
☐Child has a severe emotional disability/mental health diagnosis: _____
☐Other interventions have not been successful over time or persistent obstacles to service access and/or need for service coordination exists
☐At risk of or currently in an out-of-home placement/or in placement
☐Parents are willing to be involved in the team process

I, the undersigned, understand that a referral is being on behalf of _____
(client name)
for: ☐AODA Counseling ☐Psychotherapy ☐CCS ☐CLTS ☐CST. I further understand that participation in any of these services is voluntary and requires a commitment to attending appointments and completing any homework assignments that are part of psychotherapy.

Parent/Guardian: _____

Youth (age 14 or older):_____

If signatures are not possible, please attach documentation of a phone contact indicating the parent/guardian is aware of and in agreement with this referral.

Lisa Stephan (CLTS) – (920) 683-2792; lisastephan@co.manitowoc.wi.us
Lori Fure (CCS) – (920) 683-4981; lorifure@co.manitowoc.wi.us
Erin Stiefvater (CST) – (920) 682-5036; erinstiefvater@co.manitowoc.wi.us