Manitowoc County Human Services Department

Email Referral to: child.ref@manitowoccountywi.gov

REFERRAL FOR CHILDREN SERVICES

Please have referral form fully completed for review and assignment.
Incomplete referrals cannot be processed.

Date of Referral:

Referral Source Name/Relationship to child:

Referral Source Contact Information (email & phone number):

Reason for Referral:

Child's Name:

Preferred Name:

DOB:

Age:

Ethnicity:

Preferred language:

Need interpreter? ☐**Yes** ☐**No**

Address:

City/State:

Sex at Birth: ☐Male ☐Female
Gender Identity:

Telephone:

Type of Disability: ☐Developmental ☐Physical ☐Autism ☐Medical ☐Mental Health

PARENT/GUARDIAN/CAREGIVER INFORMATION:

Parent #1

Name:

Address:

Phone number:

DOB:

Relationship to Child: Relative Caregiver
Other, explain:

Parent #2

Name:

Address:

Phone number:

DOB:

Relationship to Child: Relative Caregiver
Other, explain:

Person Authorized to consent for Mental Health Treatment: _____

Others Living in the home:

Name: _____ ☐Adult ☐Child
Name: _____ ☐Adult ☐Child
Name: _____ ☐Adult ☐Child
Name: _____ ☐Adult ☐Child
Name: _____ ☐Adult ☐Child
Name: _____ ☐Adult ☐Child

Are there pets in the home? ☐Yes ☐No

Diagnosis – Who Diagnosed/When?

History of Mental Health Treatments and Dates:

Reason for Termination:

<u>Behavioral Concerns</u>:

☐Homicidal statements
☐Self-Harm
☐Suicidal statements*
☐Suicide attempts*
☐ Mental Health Hospitalizations*
☐Running away
☐Tantrums/meltdowns
☐Defiance
☐ Stealing
☐Sexual acting out
☐Bullying
☐Destruction of Property
☐Physical Aggression
☐ Police Contact, explain: _____ charged? ☐Y ☐N
☐ School suspensions/expulsions/missing school*:

**Explain the above checked Behavioral Concerns (When/Frequency):*

Drug/Alcohol Information:

☐Currently using:
(Frequency and route of use, last date of use)
☐Currently using tobacco.
☐Currently using alcohol.
☐Currently using Marijuana

Other Concerns not listed/Additional Comments:

Current Medications:

Current Services:

School/Teacher: Grade: IEP: ☐YES ☐NO
Pediatrician:
Psychiatrist:
Psychotherapist:
Name of social worker(s)/other worker(s):

PLEASE OBTAIN ALL RELEASES OF INFORMATION FOR RECORDS FROM PROVIDERS

____ (initial here) 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 #1: _____
Youth (age 14 or older): _____

Parent/Guardian #2: _____
Youth (age 14 or older): _____

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