

**Comprehensive Community Services  
Referral Form**

Referral Date: \_\_\_\_\_  
Referred By: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**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? \_\_\_\_\_

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 CCS?  Self  CSP  
 School \_\_\_\_\_  
 Ashland County  Bayfield County  
 Other \_\_\_\_\_

CCS Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Service Director (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: \_\_\_\_\_ Date: \_\_\_\_\_

***Please complete this form and return to:***

**Mail:** New Horizons North  
Comprehensive Community Services  
514 W. Main Street  
Ashland, WI 54806

**Fax:** 715-682-7176