P.O. BOX 897
705 EAST TIMBER DRIVE • RHINELANDER, WI 54501-0897
TELEPHONE: 715-369-2215
FAX: 715-369-2214

REQUEST FOR SERVICES/REFERRAL FORM

Date:

Briefly describe the reason you are seeking services:

Are you seeking services for (check all that apply):

☐ Developmental Disability ☐ Mental Health ☐ Substance Use Disorder

Concerns (Please choose your top 3 concerns):

Concern 1: Please choose one of the following:

Concern 2: Please choose one of the following:

Concern 3: Please choose one of the following:

Drug/Alcohol Information:

Tobacco: Please choose one of the following: Alcohol: Please choose one of the following: OtherDrugs:

Personal Information

Name of Person seeking services:

DOB: **Social Security Number:** **Age:**

Address: **Gender:** Please choose one of the following:

Contact phone: **Contact email:**

Best way to reach you: Choose one of the following:

Contacts

Do you have a guardian? Please choose one of the following: If yes, please complete below:

Name: Contact phone:

Are you under 18 years of age? Choose one of the following: If yes, please complete 1 and 2 below:

1. Mother's Name: Contact phone:
2. Father's Name: Contact phone:

Who could we contact in case we are having a hard time connecting with you?

Name: Relationship: Phone:

Living Arrangements

Who do you live with? (check all that apply)

☐ Self ☐ Roommate ☐ Significant other ☐ Spouse ☐ Children ☐ Parents

☐ Siblings ☐ Other:

Work/School: (Check all that apply)

☐ Working FT/PT ☐ Not Working ☐ Seeking Employment ☐ Student: School/Grade ____

☐ SSI ☐ SSDI

Providers

Do you take medications? Choose one of the following: If yes, please complete 1 and 2 below:

1. Medication Name:
2. Who is the prescriber? Phone number?

Current Providers: Please list the name, clinic, and phone number for each provider.

Primary Doctor:

Psychiatrist:

Substance Use Counselor:

Mental Health:

Occupational Therapist/Physical Therapist/Speech Language Pathologist:

Other:

Please check any you are currently involved with:

☐ Social Services ☐ Juvenile Justice ☐ Child Protective Services ☐ Adult Protective Services

☐ Coordinated Services Team ☐ Probation/Parole

Insurance: (check all that apply)

☐ MA ☐ Insurance(Name): ☐ Medicare ☐ Katie Beckett ☐ None

Signature

I understand that by submitting this form I will be contacted to further discuss my request for services to see if my needs can be met by The Human Service Center. Further I understand that if staff are not able to reach me directly, they have my permission to contact the person listed above as my contact.

I further understand that participation in any of these services is voluntary and requires a commitment. It will require attending appointments, completing any assignments, and completing documentation that is part of the service programs.

Signature:

Referent

Name:

Address:

Phone Number:

Does the referred person know a referral has been made? Choose one of the following:

Referral Source: _____ _____

Signature Date

If signatures are not possible, please attach documentation of a phone contact indicating the person being referred or their guardian/parent is/are aware of and in agreement with this referral. All referrals can be emailed to: **referrals@thehumanservicecenter.org**