



# REFERRAL FORM

FAX TO: 715-504-8786

## PATIENT INFORMATION

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Parent/Guardian Name & Phone: \_\_\_\_\_

Referring Provider (Name & Clinic): \_\_\_\_\_

Referring Provider Phone: \_\_\_\_\_ Email (Optional): \_\_\_\_\_

Is the Patient in the CCS Program? \_\_\_\_\_ Case Manager (if applicable): \_\_\_\_\_

## REFERRAL DETAILS:

### Reason(s) for Outpatient Counseling:

### Requested Therapist:

- |                            |                                |
|----------------------------|--------------------------------|
| ADHD                       | OCD                            |
| Adjustment to Medical Dx   | Panic Attacks                  |
| Anger Management           | Parenting Education/Support    |
| Anxiety                    | Perinatal/Postpartum Struggles |
| Bipolar Disorder           | Relationship Issues            |
| Depression                 | School Struggles               |
| Eating Issues              | Sex Addiction & Recovery       |
| First Responders Stressors | Sleep Difficulties             |
| Grief/Loss                 | Social Skills                  |
| Men's Issues               | Stress Management              |
| Menopause/Women's Issues   | Trauma/Abuse                   |
|                            | Veterans & Family Issues       |

- Any/No Preference
- Ann Dixon, LPC
- Hannah Bunting, LCSW
- Ireland Calo, LPC-IT
- Jessica Wilharms, LPC
- Jovid Schuette, LPC
- Madison Baumgart, LPC-IT
- Mindy Schuette, LCSW
- Samantha Papka, LPC-IT

Other: \_\_\_\_\_

ADDITIONAL COMMENTS: \_\_\_\_\_

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### Referral Follow-Up Info:

Intake appointment scheduled.

Date of Appt: \_\_\_\_\_

Time: \_\_\_\_\_

3 attempts were made, client did not respond.

Client declined services.

### Contact Us:



516 McClellan St  
Wausau, WI 54403



715-226-6441



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