



REFERRAL FORM

FAX: 715-504-8786

EMAIL: ADMIN@NEWINSIGHTSWAUSAU.COM

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:

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

Other: _____

Requested Therapist(s):

- 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

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



admin@newinsightswausau.com