NEW INSIGHTS
COUNSELING

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:

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

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: _____

_____

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