



REFERRAL FORM

PHONE: 715-226-6441 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 | ☐ OCD |
| ☐ Adjustment to Medical Dx | ☐ Panic Attacks |
| ☐ Anger Management | ☐ Parenting Education / Support |
| ☐ Anxiety | ☐ Perinatal / Postpartum Struggles |
| ☐ Bicultural Stressors | ☐ Relationship Issues |
| ☐ Bipolar Disorder | ☐ School Struggles |
| ☐ Depression | ☐ Self-Harm |
| ☐ Eating Issues | ☐ Sleep Difficulties |
| ☐ First Responders Stressors | ☐ Social Skills |
| ☐ Grief / Loss | ☐ Stress Management |
| ☐ Men's Issues | ☐ Trauma / Abuse |
| ☐ Menopause/Women's Issues | ☐ Veterans & Family Issues |

Other: _____

Requested Therapist(s):

- ☐ Any / No Preference
- ☐ Ann Dixon, LPC
- ☐ Hannah Bunting, LCSW
- ☐ Ireland Calo, LPC-IT
- ☐ Jordan Peters, LPC-IT
- ☐ 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: _____

- ☐ Multiple 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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