www.icc-wi.org
128 E. Olin Ave Suite 201
Madison, WI 53713
608.316.1141 TEL

ICC Referral Form-CCS

Date of Referral: _____

Consumer Information	
Consumer Name	
Date of Birth	
Home Address	
Home Phone	
Mobile Phone	
Email Address	
Diagnosis	
If applicable, complete parent/guardian information below	
Parent/Guardian Name(s)	
If not legal healthcare guardians for consumer, has the Release of Information been signed that allows consumer's parents' permission to communicate with ICC staff on behalf of this consumer? YES _____ NO _____ N/A _____	
Home Address	
Home Phone	
Mobile Phone	
Email Address	
Program Information	
County of Residence	
Case facilitator name	
Case facilitator phone/email	
Service Request(s) for Consumer	
Service Request/Code	_____ Individual Skill Development _____ Diagnostic Evaluation (FBA, or other evaluation) _____ Psychoeducation-for consumer _____ Psychoeducation-for parent or family _____ Psychotherapy _____ Wellness Management and Recovery Specific Provider Request: _____ *

	Specific Treatment Modality Request(s): _____* Availability for treatment: _____* *Please note that limited or evening hours and/or requests for specific providers or treatment modalities may vary by county location and increase wait time
Requested frequency of service(s)	 Is telehealth an option for service(s)? Yes/No
Background information to support referral	
Presenting concerns which led to referral: **Is there a history of trauma?** Y or N _____	
Background information: (family, consumer, school, work, community) that may be helpful to match provider with consumer, including any concerns about aggression or recent hospitalization(s).	

Thank you for your referral. Please submit to kschmidt@icc-wi.org or contact Kimberly Schmidt at (608) 291-9210 if you'd like to talk more about the referral.