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

ICC Referral Form-CLTS

Date of Referral: ____

Client Contact Information	
Last Name, First Name	
Date of Birth	
Diagnosis:	
Parent/Guardian 1	
Home Address	
Home Phone	
Mobile Phone	
Email Address	
Parent/Guardian 2	
Home Address	
Home Phone	
Mobile Phone	
Email Address	
Program	
County of Residence	
Case manager/facilitator name	
Case manager/facilitator phone/email	
Service Request(s) for Consumer	
Service Type	_____ Empowerment and Self-Determination Supports (Formerly Consumer Education and Training) _____ Family/Unpaid Caregiver Supports and Services (Formerly Training for Unpaid Caregivers) _____ Counseling and Therapeutic Services Specific Provider Request: ____* Specific Treatment Modality Request(s): ____*

July, 2020

	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)	Circle or highlight one: Weekly Bi-weekly Monthly Other:_________________________________ Is telehealth an option for service? ____

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, community) that may be helpful to match provider with consumer: Please note any concerns about aggression, any recent hospitalization(s).

Thank you for your referral. Please submit to Lhoeme@icc-wi.org or call Lisa Hoeme at (608) 291-9199 if you'd like to talk more about the referral.