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

ICC Referral Form-Private Pay

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	
Service Request(s) for Consumer	
Service Type	_____ Psychoeducation _____ Psychotherapy _____ Parent Coaching _____ Individual Skill Development _____ Functional Behavioral Assessment 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? ___________________________
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 lladson@icc-wi.org or call Lisa Ladson at (608) 291-6186 if you'd like to talk more about the referral.