Mental Health America of Wisconsin

Referral Form

Name of Person Completing Form:	Relationship to Client:	Contact Information:	Date Completed:

Client Name:	Age/DOB:
Street Address:	City/State/Zip Code:
Phone Number:	Alternate Phone Number:

Which program(s) is the client interested in learning more about?

- ❑ Strong Families Healthy Homes
- ❑ Mental Health Therapy

Mental Health and/or Substance Use

Psychiatrist Name and Contact Information:	Therapist Name and Contact Information:
Diagnosis:	Medications:
Symptoms of Concern:	Drug or Alcohol Use (history and/or current):

Children

Name:	Age/DOB:	In Home (Y/N) or Placement:	Special Needs:

Service Providers *(please list any other service providers that are involved with the client)*

1.
2.
Is the family involved with the Division of Milwaukee Child Protective Services? □Yes □No If yes, please explain the status of the family's involvement:

600 West Virginia Street, Suite 502, Milwaukee, WI 53204
Phone: 414-276-3122 Fax: 414-276-3124

Please respond to the following questions to help us determine what services will best meet the client's needs.

Description of presenting problem:
Any additional information regarding the client:

Parenting Information, if applicable

What are the parent's goals related to his/her mental health and/or substance use?
What are the parent's goals related to parenting?
Any additional information regarding the parent, the parent's needs or the family?

Pregnancy Information, if applicable

How far along is Mom in her pregnancy? What is the due date?
Are there any current medical concerns re: this pregnancy?
How does Mom feel about this pregnancy?

Completed referrals should be e-mailed, faxed or mailed <u>along with a signed Consent for Release of Information</u> to referrals@mhawisconsin.org. Once a referral is received, it is reviewed by MHA staff and a call is placed to the referent for more information. Next, an intake meeting will be scheduled. If the individual and program are determined to be a good fit by all parties, they will be admitted to the program at that time.

Mental Health America of Wisconsin

CONSENT FOR RELEASE OF PERSONAL RECORDS

1	**I hereby authorize**: Mental Health America of Wisconsin 600 West Virginia Street, Suite 502, Milwaukee, WI 53204
2	☐ **To release information to**: Agency and/or Individual____ Street/City/State/Zip____
3	**From the records of**: Client name_________________________________ Date of birth______________ Other names used____
4	**Purpose or need for disclosure**: *(check all that apply)* □ Service coordination □ Mental health and/or substance abuse assessment/treatment □ Crisis management □ Individual is requesting personal records to be disclosed to self
5	**Types of information to be disclosed**: *(check all that apply)* □ Intake Summary □ Progress Notes/Reports □ Treatment Plans □ Parenting Strengths and Goals □ Clinical Impressions □ Other *(specify)*____
6	**I understand that**: *(a) The information released is confidential and protected from further disclosure.* *(b) I have the right to cancel my permission to release information at any time.* *(c) I am not required to sign this form and may refuse to do so* *I hereby authorize the periodic release of the above information to the person/organization/facility/program identified above as often as necessary to plan for, provide care, services and treatment.*
7	**This consent is valid** for the release of the above stated records and to the above stated individual on one ___ or multiple ___occasions. Records will be released within ten business days.
	____ ________________ Client Signature Date ____ ________________ Parent or Guardian Date ____ ________________ Witness Signature Date
	Dates of service this consent/(ROI) Release of Information covers: **Note:** (This release will expire one year after it was first signed unless otherwise indicated) If consent is ended less than one year after it was signed: Date Consent/(ROI) is Terminated:_________ ____________________ ____________________ ____________________ Client Signature Date Parent or Guardian Date Witness Signature Date

– A PHOTOCOPY, FAX OR ELECTRONIC IMAGE OF THIS CONSENT SHALL BE AS VALID AS THE ORIGINAL –

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