**Mental Health America of Wisconsin**

**Referral Form**

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| --- | --- | --- | --- |
| 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: |

*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**

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| --- |
| 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**

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| --- |
| 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 along with a signed Consent for Release of Information 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.**



**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 onone \_\_\_ 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 –