

# Impact Counseling Services — Ashland

## Impact Therapeutic Day Treatment — Referral Form

Child/Adolescent Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_

Presenting Problems:

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Goals for Treatment:

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Funding Available:

Medical Assistance or BadgerCare     Private Pay     Other \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_  
Address (if different): \_\_\_\_\_  
\_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Is the parent/guardian supportive of this referral?     Yes     No

Name of Foster Parent (if in foster care): \_\_\_\_\_

Address: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring Person:

Name: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_  
Agency: \_\_\_\_\_  
\_\_\_\_\_ Fax Number: \_\_\_\_\_

The parent/guardian must sign this form, giving us permission to contact them before we can call to set up an appointment for an assessment. Please make sure this has been done before contacting us. Please mail or fax this form to Impact Counseling Services, 301 Ellis Avenue, Suite 1, Ashland, WI 54806. Our fax number is **(715) 682-3526**. If you have any questions, please call us at **(715) 682-3523**. *Thank you for your cooperation and thank you for this referral.*

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Today's Date: