

Impact Counseling Services — Hayward

Impact Therapeutic Day Treatment — Referral Form

Child/Adolescent Name: _____ Today's Date: _____
Address: _____ Phone Numbers: _____

Date of Birth: _____
Social Security No.: _____

Presenting Problems:

Goals for Treatment:

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, P.O. Box 13251, Hayward, WI 54843. Our fax number is **(715) 634-0617**. If you have any questions, please call us at **(715) 634-0607**. *Thank you for your cooperation and thank you for this referral.*

Parent/Guardian Signature

Today's Date: