***Referral for Services at Grace Counseling & Family Services, S.C.***

 ***304 Bickford St PO Box 17 New Lisbon, WI 53950***

***Please fax to: 608-562-3975 or email to: klombard.gcfs@gmail.com or office.gcfs@gmail.com***

***Questions please call Kacey Lombard at 608-581-2227***

***Referral Information***

***Date:*** ***Agency you work for:*** ***CCS*** ***County***:

***Name of person making referral:*** ***Phone Number:***

***Email Address:***

***Services Being Requested (please check):***

***Master’s-Level Bachelor’s-Level***

[ ] male[ ] female [ ]  no preference [ ] male[ ] female [ ] no preference

[ ]  Psychotherapist-masters level [ ] Mentor-bachelor level

[ ]  Therapeutic Youth Mentor-masters level [ ] Parent mentor-bachelor level

[ ]  Family Therapist-masters level [ ] Psychosocial Rehab Worker

[ ] Parent Support-masters level

Provider requests:

***Consumer Information:***

***Name of Identified Consumer/ID#:*** ***DOB:***

***Name of Person Needing Services(such as family member):*** ***DOB:***

***Address:*** ***Phone Number:***

***Name of Parents/Guardian:***

***Relationship:***  ***Phone Number:***

***School and school supports:***

***Strengths:***

***Presenting Problem(s):***

***Diagnosis:***

***Goal(s) to be addressed:***

***Other services and team members involved:***

***Other relevant information:***

***If known, time of day being requested:*** [ ] open/flexible [ ]  mornings [ ]  afternoons [ ]  after school

 [ ]  during school [ ]  evenings [ ]  other:

***How many hours per week requested:***

\*\*\*\*\*\*Please attach recovery plan. assessment, and team roster if you feel it would be helpful for referral purposes.