# EAU CLAIRE COUNTY
# Coordinated Services Team

Eau Claire County
Department of Human Services
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## Referral Form

**Name of child** (include middle initial): _____

**Date of Birth:**_____ **Age:** _____ **SSN: (Optional)** _____

***Complete the following information if*** *different from above:*

**Caregiver/Parent(s) Name**: _____ **Home Phone**: _____

**Address:** _____ **Work Phone:** _____

**Referral Person:**_____ **Referral Date:**_____

**Phone Number:**_____ **FAX #:**_____

**Reason for Referral:**_____

Are there any safety concerns for the family (violent behavior, unsafe conditions)?

_____

_____

Is the child at risk of out of home placement or hospitalization? If so, please explain.

_____

_____

**Funding source** (check): ☐MA ☐SSI ☐Katie Beckett ☐Private Insurance ☐Parents ☐Other (please describe) _____

**Please check all that apply:**

☐ Use of multiple direct services (e.g. mental health, special education, juvenile justice, child protective services, alcohol or other drug services)

☐ Other interventions have not been successful over time, or persistent obstacles to service access and/or need for service coordination exists

☐ At risk of out of home/institutional placement

☐ Parents are willing to be involved in the CST process

**List other significant people *not* in the home** (please include age and relationship):

_____

_____

# Service Provider Information

***Does the child have a Mental Health diagnosis?***

**Mental Health Provider:** _____

**Contact Person:** _____ **Phone Number:** _____

**Fax #:** _____

**Describe Involvement:** _____

_____

_____

***Is the child involved with the Juvenile Justice system, Child Protective Services (CPS), or Alcohol/Other Drug Abuse (AODA)services?***

If ***yes***, please complete the provider information below.

If ***no***, please continue with "Educational Provider" information.

**Juvenile Justice, CPS, or AODA Service Provider:** _____

**Contact Person:** _____ **Phone Number:** _____

**FAX #:** _____

**Describe Involvement:** _____

_____

_____

_____

**Educational Provider:**

**Special Education? Yes ☐ No ☐**

**Contact Person:** _____ **Phone Number:** _____

**FAX #:** _____

**Describe Involvement:** _____

_____

_____

_____

**Other Agency/Provider:** _____ **Phone Number:** _____

**Describe Involvement:** _____

_____

_____

_____

**Please describe the concerns you have about this child and/or family**

Behavior: _____

_____

Emotional state: _____

_____

Physical disabilities: _____

_____

Other: _____

_____

## Consent for Referral and Participation

I give my consent to _____ to refer my child and family members as identified to the Eau Claire County, Coordinated Services Team (CST). I agree to participate in the team process and to play an active role in the assessment and case planning processes.

I understand that I will be asked to identify the service providers working with my family and to sign release forms authorizing the exchange of information. I realize that as long as our family is involved in the CST, it will be necessary for service providers to routinely review and share information.

_____ Date _____
Signature of Individual Authorizing Referral

_____ Date _____
Second Authorization/Witness Signature