Marriage & Family Health Services, Ltd.

2925 Mondovi Road • Eau Claire, WI 54701 • 715-832-0238 • 1-800-639-4044 • Fax 715-832-0771
Offices also in Chippewa Falls 715-726-9208, Hudson 715-381-5437, & Marshfield 715-486-8302

Referral Form

CLINICAL SERVICES
Diagnostic/Evaluation Services:
Family Evaluation
Psychological Evaluation

Treatment/Solutions For:
Anger Management
Anxiety Management
Behavior/School Problems
Blended Families
Child/Adolescent Concerns
Depression
Divorce & Mediation
EMDR for Abuse/Trauma
Faith Based Concerns
Family Discord
Grief/Loss/Disappointment
Gottman Method Couples Counseling
Intimacy & Sexual Concerns
LGBT Concerns
Play Therapy
Relationship Enrichment
Stress Management
Thinking Errors
Trauma Re-Processing

Agency & Organizational Consultation:
Case Specific Consultation
In-Service Training

OFFICES:
Main/Billing:
2925 Mondovi Road
Eau Claire, WI 54701
P (715) 832-0238
F (715) 832-0771

405 Island Street
Chippewa Falls, WI 54729
P (715) 726-9208
F (715) 726-8731

501 South Cherry Avenue Suite 5
Marshfield, WI 54449
P (715) 486-8302
F (715) 486-9253

2910 Enloe Street
Hudson, WI 54016
P (715) 381-KIDS (5437)
F (715) 381-5438

Today's Date: _____

Purpose of Referral: ___ Mikan/Migisi Day Treatment ___ Family Counseling
___ Individual Counseling-Child/Adolescent
___ Individual Counseling-Adult ___ School Based Counseling

Client Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____

Name of Parents/Guardians: _____

Parent's Address (if different): _____ Phone: _____

_____ Email: _____

Have parents been consulted about this referral? ___ Yes ___ No

Are parents supportive of this referral? ___Yes ___ No

Any comments regarding parental input: _____

Is the client willing to participate in therapy?___ Yes ___No

Is participation court ordered? ___ Yes ___ No

Is participation a condition for continued school attendance? ___ Yes ___ No

REFERRAL DOES NOT OBLIGATE THE REFERRING PERSON, AGENCY, OR SCHOOL TO PAY FOR COUNSELING SERVICES.
MFHS STAFF WILL WORK WITH THE CLIENT'S FAMILY TO ESTABLISH FUNDING SOURCE.

Person making referral:_____ Relationship to client: _____

Agency/School: _____

Address: _____

Phone: _____ Email: _____

Reasons for referral: _____

_____

_____

FOR OFFICE USE ONLY:

Follow-up Status:

Case Manager/Therapist Involved: _____

_____ Parent has agreed to program/counseling services. The initial meeting will be on _____.
(Date)

_____ Parent did not agree to counseling. Plan: _____

_____

Funding Source: ____ Private Insurance ____ Medicaid/BadgerCare/Forward Health ____ Medicare
____ Private Pay ____ County ____ School

CC: ____ Parent/Guardian _____ Referral Source
____ County Human Services _____ School Contact
____ MFHS Main Office _____Other (specify) _____