APPLETON · FOND DU LAC · GREEN BAY · GREATER MILWAUKEE
SHIOCTON · NEW LONDON
E7475 RAWHIDE RD., NEW LONDON, WI 54961-9052
PHONE 1-877-300-9101 FAX (920)982-5040 RAWHIDE.ORG

School-Based Mental Health Program Referral Form

Student's Name: _____ Date of Birth: _____
Address: _____ Phone Numbers: _____
_____ _____
School Attending: _____

Presenting Problems:

_____
_____
_____
_____

Goals for Treatment:

_____
_____
_____
_____

Payment Type:
☐ Private Insurance (Name of Ins. Co.) _____ ☐ Cash
☐ BadgerCare ☐ Other _____

Parent/Guardian Name: _____ Date of Birth: _____
Address (if different): Phone Numbers: _____
_____ _____
_____ Email Address: _____
Is the parent/legal guardian supportive of this referral? ☐ Yes ☐ No

Name of Foster Parent (if in foster care): _____
Address: _____ Phone Numbers: _____
_____ _____
_____ Email Address: _____

Referring Person:
Name: _____ Phone Numbers: _____
School or _____ _____
Agency: _____ Fax Number: _____

We must receive this completed form before we can discuss any information specific to this referral.

Parent/legal guardian must sign this form, giving us permission to contact them to set up an appointment for an assessment. A session will be scheduled after insurance coverage is verified or other payment options have been set up.

Please mail or fax this form to Rawhide Youth Service, Attn: Outpatient Counseling, E7475 Rawhide Road, New London, WI 54961. A follow-up call is appreciated to verify the referral has been received. Our fax number is **(920) 531-2686**. If you have any questions, please call us at **877-300-9101** or email us at **outpatient@rawhide.org**.

_____ _____
Parent/Guardian Signature Today's Date: