FORWARD
Counseling & Consultation

Please fax completed CCS Referral Form to Forward Counseling, 2000 Engel Street, Suite 201 Monona, WI, 53713
Phone: 608-455-6070, **Fax: 608-455-0883**

Client Legal Name: **Referral Date:** **Preferred Name:** **DOB:**		**Parent(s) (under 18 years of age):** **Legal Guardian:**
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino **Race:** ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Prefer not to respond		**Gender Identity (select all that apply)**: ☐ Female ☐ Male ☐ Transgender ☐ Non-binary/non-conforming ☐ Prefer not to respond **Housing:** ☐ Independent Living ☐ Group Home ☐ Foster Care ☐ Sober Living ☐ Homelessness
Address:		**Phone:**
City: **State:** **Zip Code:**		
Email:		

Therapy Location:	**Service(s) requested:**	**Authorization of Hours:**	**Presenting Concern(s):**
☐ Office ☐ Telehealth ☐ Community ☐ Phone	☐ Therapy ☐ ISD ☐ Psychoeducation	☐ Yes _____ hours per week ☐ No	☐ Mental Health ☐ Substance Use ☐ Trauma ☐ Psychosis

Service Facilitation Agency

Agency Name:	Service Facilitator:	Phone:
Email:		

Psychiatry Agency

Agency Name:	Prescriber Name:
Phone:	Email:

Emergency Contact

Name:	Address:	
Relationship to Referral:	Home Phone:	Cell Phone: