Community Services
Prevention Programs
620 S. 76th Street, Ste. 120, Milwaukee, WI 53214
Telephone: Kara Singleton, (414) 231-4827
Fax Referral to: (414) 453-2538
Or scan & email to: Kara.singleton@cssw.org

REFERRAL FORM

Referring Provider: ____ **Referral Date/Time:** ______________________

Office/Address: ____

Telephone: (_______)_______________________ **Fax: (_______)**_____________________ **Email:** ____________________

FAMILY INFORMATION:

1. Parent/Caregiver Name: _____________________________ **2. Parent/Caregiver Name:** ___________________________

Address: ____ **Address:** ____

Telephone: (_______)____________________________ **Telephone: (_______)**________________________

Cell: (_______)__________________________________ **Cell: (_______)**_____________________________

Are the children currently in out of home care?: ☐ Foster Care ☐ Kinship Care ☐ N/A

1. **Name of Child:**_________________________________ ☐ **Male** ☐ **Female** **DOB:**______________________

   Any concerns/special needs:____

2. **Name of Child:**_________________________________ ☐ **Male** ☐ **Female** **DOB:**______________________

   Any concerns/special needs: ____

3. **Name of Child:**_________________________________ ☐ **Male** ☐ **Female** **DOB:**______________________

   Any concerns/special needs: ____

CURRENT FAMILY NEEDS, STRENGTHS AND SUPPORTS:

Reason for Referral:____

____

____

Identified Family Strengths (optional):____

____

Is there any involvement of other relatives and supports? If so, please list (optional):___________________________________

____

AUTHORIZATION:

I give Children's Hospital of Wisconsin Community Services permission to contact me at the phone numbers provided to facilitate this referral and to contact my child's referring provider to share information regarding this referral.

Parent/Guardian Signature: ____ **Date:** __________________

FRC OFFICE USE ONLY
Date Received:_____________ Staff Assigned:____
☐ Referral Accepted Date and Time of first contact: _______________________________________
☐ Referral Denied Reason: ____
Notes: ____
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