| Rocky Hill | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CCS Referral | | | | | | | | |
|  | Place an X in the box to the **left** of the appropriate option. | | | | | | | |
| CCS Consumer Name: |  | | | | | | | |
| Age of Consumer |  | | | | | | | |
| Area of Need |  | Mental Health |  | Substance Abuse |  | Both | | |
| Parent/Guardian Name(s): (if child) |  | | | | | | | |
| City/Village of Residence and what part (in town, north, south, east, west, etc.): |  | | | | | | | |
| School District of Residence |  | | | | | | | |
| Grade in school (if applicable) |  | | | | | | | |
| School Option (if applicable) |  | School of residence |  | Day Treatment |  | Home Schooled |  | Online |
| Best Form of Contact |  | Phone call |  | Phone text |  | Phone call and/or text |  | email |
| Contact Information |  | | | | | | | |
| First Contact Should be |  | Provider contact Consumer |  | Consumer contact  Provider |  | Provider  Contact Service Provider | | |
| Summary of Reason for Referral |  | | | | | | | |
| What else is important to know: (preferred place to meet, condition of home, pets, cultural, racial, gender identification considerations, language, family dynamics, etc.) |  | | | | | | | |
| **Send this form to Michelle Uetz at:** [**michelleuetz@rockyhillco.com**](mailto:michelleuetz@rockyhillco.com) **Phone: 715-505-5342** | | | | | | | | |