

**UNIFIED COMMUNITY SERVICES  
REFERRAL FOR CHILDREN'S SERVICES**

Date of Referral: \_\_\_\_\_

**FAMILY INFORMATION**

Child's Name (last, first, middle)		Child's DOB Gender	
Parents Names		Address	
Phone		County	
Best time to call		<b>EMAIL:</b>	

**REFERRAL SOURCE**

Person making referral/Physician	
Agency/Clinic	
Address	
Phone	

**THE FOLLOWING MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED:**

Diagnosis		Description of presenting problem (not delay): Give examples.
Service requested		

**INSURANCE INFORMATION**

Insurance Number/ID

Name/Group#	
Medical Assistance- Badger Care	

-----OFFICE USE ONLY-----

FAX TO: Patti Heer  
 Unified Community Services  
 (608) 723-4417  
 Or Call Patti 723-6357 if you have any questions

Directions:

Follow up: