Eau Claire County - Department of Human Services
721 Oxford Avenue, Suite 1001
Eau Claire, WI 54703
(715) 839-2300 | Fax (715) 831-5784
www.eauclairecounty.gov
Angela Weideman, Director

Eau Claire County
Coordinated Services Team

Referral Form

Name of Child: ____

Date of Birth: __________ **Age:** ________ **SSN (Optional):** ______________________________

Caregiver/Parent(s) Name: ____

Address: ____

Phone Number: ____________________ **Email:** ______________________________________

Current DHS Involvement: ____

Referral Person: ____

Reason for Referral: ____

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Consent for Referral and Participation:

I give consent to ______________ to refer my child and family members as identified to Eau Claire County, Coordinated Services Team (CST). I understand that I will be asked to identify the service providers working with my family and to sign release forms authorizing the exchange of information.

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Signature of Individual Authorizing Referral **Date**

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Authorization/Witness Signature **Date**