REFERRAL TO WINDSOR AREA INTERAGENCY CARE MANAGEMENT TEAM

Date: ___________________________

Referring Agency

Agency: Telephone:

Address: Fax:

Email address:

Client Information

Name: Telephone:

Address: Messages can be left with:

Email address:

Brief Description of Need

AGENCIES REQUESTED FOR ATTENDANCE

☐ Mt. Ascutney Hospital and Health Center Community Health Team

☐ Children Integrated Services

☐ Vermont Adult Learning

☐ Area Parent Child Center (Specify): ___________________________________

☐ Supported Housing (Specify): ___________________________

☐ Council on Aging

☐ HCRS

☐ Vermont Economic Services

☐ Division Family Services

☐ SEVCA

☐ Department of Vermont Health Access/ Vermont Chronic Care Initiative

☐ Division of Probation and Parole

☐ Voc Rehab

☐ School (Specify role): _______________________________

☐ Other (Please specify) ____

Please indicate if the family will be in attendance at the meeting ☐ Yes ☐ No

☐ Consent to communication and disclosure of health information for coordination of treatment services has been signed by involved individual.

Date Team Met: ______________________________

Team Members Present

Name: Agency: Email address:	Name: Agency: Email address:
Name: Agency: Email address:	Name: Agency: Email address:
Name: Agency: Email address:	Name: Agency: Email address:

Action Plan

Action	Responsible Person	Time Frame

Follow Up

Follow up Scheduled for ______________________________ ____________________
Date Time