CRISIS RESPONSE

Initial Information Form

Name of person filling out this form:

Address:

Phone:

Fax:

Date:

Relationship to consumer:

Consumer's Name:

Address:

Phone: Guardian Name:

Date of Birth: Guardian phone #:

Height: Weight:

Diagnosis (include DHS/ACS Diagnostic Code & Client Characteristics if available):

ACS#: Social Security #:

Family contact(s):

Doctor / Clinic:

Medications:

Allergies:

Ambulation:

_Diet (include food preferences/dislikes):

Hearing:

Vision:

Communication:

Toiletting:

ADL:

Sleep:

Other health related information:

Service providers involved (agency, contact name and #, description of service):

Residential:

Current:

Past:

Vocational:

Current:

Past:

Other:

Typical weekly schedule/routine:

Time	Mon	Tues	Wed	Thur	Fri	Sat	Sun

Activities / interests:

Likes:

Dislikes:

Activity level:

Behavioral Information:

Behavioral issues of concern/challenges:

_Stress factors (precipitating, contributing):

_Approaches/Strategies used to address:

_Other helpful information :

Community TIES — Waisman Center / CSU
Training, Intervention, and Evaluation Services
122 E. Olin Ave, Ste. 100
Madison, WI 53713
608-265-9440
608-263-4681 FAX

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

________________________ ________________________ ______________
Consumer Name Social Security Number Date of Birth

I authorize Community TIES to disclose and receive information and records to and/or from the persons/ organizations/ agencies listed below for the purpose of sharing information relevant to the emotional/ behavioral well-being of the consumer. Disclosure under this release includes access to records, permission to obtain copies of records, and oral discussion of information between agency staff and individual service providers.
(Please note: when using a copy of this release form in connection with a request for information from one of the persons/organizations/ agencies listed, the names of the other persons, etc.. that do not pertain to a particular request will be blocked out to protect the confidential nature of this information).

AGENCIES, ORGANIZATIONS, INDIVIDUALS	**ADDRESS**	**TYPE OF RECORDS/ DATES**
		All records (medical, psychological and other)

Send to: **Community TIES Program**
122 E. Olin Ave, Ste. 100
Madison, WI 53713

A photocopy of this authorization has the same effect as the original.

I understand that I may withdraw this consent at any time by sending a written request. However, reports sent prior to withdrawal of consent cannot be recalled. I also understand that I may inspect and receive a copy of the disclosed information.

I hereby consent to the release of information as described above.

* ______________________________ ______________
Signature of Consumer Date

* ______________________________ ______________
Signature of Witness Date

* ______________________________ ______________
Signature of Legal Guardian (if applicable) Date