Trailhead Therapy & Mentoring

(Driftless Counseling LLC)

www.TrailheadTM.org
Phone: 608.606.6789 Fax: 608.640.3513

Referral Form

Submit to info@trailheadtm.org

Case Manager / Service Facilitator Information:

Facilitator Name: ______________________ Phone Number: ______________________
Agency: ______________________ Email: ______________________

Client Information:

Client Name: ______________________ CCS Case Number: ______________________
Date of Birth: ______________________
Parent / Guardian Name: ______________________
Phone Number: ______________________
Address: ______________________

Reason for Seeking Support:

____
____
____
____

Has the Client participated in counseling before? Yes No If yes, dates (yrs): ________

What was most helpful? ______________________

Pairing Client with the right provider:

Which therapeutic activities do you believe would work best for the client?

Art Play Active/Outdoors Family Therapy Music

The Client would prefer to work with: Male Provider Female Provider No Preference

Types of provider(s) needed: Mentor Therapist Family Therapist

Other Preferences / needs:

____
____
____
____
____

When would the client be available to meet?

After-School   During School Hours   Weekday Evenings   Weekends

Other Scheduling considerations:

____

____

Has the client witness or experienced any of the following?

Sexual Abuse
Physical/Domestic Abuse
Verbal / Emotional / Bullying Abuse

Other trauma background we should know about?

____

____

Client's existing diagnose(s): ____

Medications (if known): ____

- -

Please complete the following * ***OR*** * attach the CCS Recovery Plan

Briefly, what are the client's strengths or interests?

____

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____

____

Briefly, what are the client's challenges or barriers?

____

____

____

____

What are the Client's CCS treatment goals?
Goal 1: ____
Goal 2: ____
Goal 3: ____
Goal 4: ____

Please submit completed form to
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