

# Trailhead Therapy & Mentoring

(Driftless Counseling LLC)

www.TrailheadTM.org

Phone: 608.606.6789 Fax: 608.640.3513



## Referral Form

Submit to

Intakes@TrailheadTM.org

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### Case Manager / Service Facilitator Information:

Facilitator Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Agency: \_\_\_\_\_ Email: \_\_\_\_\_

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### Client Information:

Client Name: \_\_\_\_\_ CCS Case Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Client Pronouns: \_\_\_\_\_  
Parent / Guardian Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

Relevant Cultural Information:

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    Music    Community Skills

Other: \_\_\_\_\_

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:

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Has the Client witnessed or experienced any of the following?

Sexual Abuse

Physical/Domestic Abuse

Verbal / Emotional / Bullying Abuse

Other trauma background we should know about?

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Client's existing diagnoses: \_\_\_\_\_

Medications (if known): \_\_\_\_\_

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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?

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What are the Client's CCS treatment goals?

Goal 1: \_\_\_\_\_

Goal 2: \_\_\_\_\_

Goal 3: \_\_\_\_\_

Goal 4: \_\_\_\_\_

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