

***Client Referral Form***

Twelve Oaks Center for Healing and Sexual Wellness
Please complete the entire form to the best of your ability and email to javin@twelveoakswi.com or call Javin at 651.560.3139 with any questions.

**Date of Referral:** Click or tap here to enter text.

**Individual or Couple:** Click or tap here to enter text.

**Client’s Name** Click or tap here to enter text.

Pronouns: Click or tap here to enter text.

Gender: Click or tap here to enter text.

DOB: Click or tap here to enter text.

Address: Click or tap here to enter text.

 Click or tap here to enter text.

Preferred Contact Information: Click or tap here to enter text.

**Partner’s Name** Click or tap here to enter text.

Pronouns: Click or tap here to enter text.

Gender: Click or tap here to enter text.

DOB: Click or tap here to enter text.

Address: Click or tap here to enter text.

 Click or tap here to enter text.

Preferred Contact Information: Click or tap here to enter text.

Please Note Any Helpful Information for Contact: i.e., best days/times, preferred method, guardian contact information if applicable, additional partner(s). Click or tap here to enter text.

**Referent Information**

Referent Name: Click or tap here to enter text.

Agency/County/CCS Program: Click or tap here to enter text.

Preferred Contact Information: Click or tap here to enter text.

Email: Click or tap here to enter text.

Supervisor Name: Click or tap here to enter text.

Supervisor Preferred Method of Contact: Click or tap here to enter text.

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**Additional Information**

**Why have you chosen to refer this individual or couple for services at this time?** Click or tap here to enter text.

**What is the individual/couple hoping to get from therapy?** Click or tap here to enter text.

**Is the individual engaged in therapy with another provider?** Click or tap here to enter text.

**Is the individual seeking primarily telehealth, in-home, or office-based therapy?** Click or tap here to enter text.

**Any Additional Information:** Click or tap here to enter text.

**CCS Referrals Only**

Service Array Category: \_\_\_\_\_\_\_\_\_\_ Psychotherapy

 \_\_\_\_\_\_\_\_\_\_ Wellness Management

 \_\_\_\_\_\_\_\_\_\_ Individual and/or Family Psychoeducation

 \_\_\_\_\_\_\_\_\_\_ Individual Skills Development and Enhancement

CCS Recovery Plan Goals:

1. Click or tap here to enter text.
2. Click or tap here to enter text.

*Thank you for your referral, we look forward to working with you!*