**A logo for a company

AI-generated content may be incorrect.**

**Trauma Recovery Center Referral Form**

*Please return this completed form to TRC Program Director:*

*Jaida Richardson at* [*jrichardson@astorservices.org*](mailto:jrichardson@astorservices.org)

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| **Referral Made by**:                                                   **Title**: |
| **Agency/Program**:         **Phone**:     **Email**: |

Please check:                                                            YES             NO

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| --- | --- | --- |
| Is this potential client a Bronx Resident? |  |  |
| Is this potential client 5 years of age of older? |  |  |
| Has this potential client been a victim of a violent crime in the last 3 years? |  |  |
| Has this potential client lost a loved one to homicide in their lifetime? |  |  |

Referral Date:  \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intake Scheduled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does client have a signed consent to be contacted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assigned Clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Client Name:       D.O.B.      Gender: |
| Street Address: |
| City:   State:            Zip: |
| Telephone:           Email address: |
| Primary Language:           Ethnicity:           Religion:  Preferred Language:  (if Hispanic/Latino indicate Country: \_\_ **\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| Marital Status: |
| Sexual Orientation:            Preferred Pronouns:               Preferred Name: |
| Is this person a previous TRC client? |
| Is this person currently receiving mental health services?  Currently on psychotropic meds? |
| Has this person expressed suicidal or homicidal ideation in the past or present? Explain |
| Is this person open to home visits?      Open to clinic visits?     Open to telehealth? |
| Is this person currently experiencing domestic violence or intimate partner violence? |

TRC referral form    Page 2

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| Household Members’ Names | D.O.B. | M/F | School/Grade/Occupation | Relation | Ethnicity |
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| Type of Trauma: (Sexual Assault, Domestic Violence, Physical Assault, Stabbing, Shooting, Vehicular Assault.   Family of Victim, Other crime, non-crime related trauma, torture/war trauma, gender-based violence, Human   trafficking) |
| **Date and Duration of Trauma:** |
| Impact on Daily Functioning: |
| Trauma perpetrated by whom? Is there current contact? |
| Does Client have a Substance Abuse History? Yes:  \_\_\_\_\_\_\_\_\_ No:  \_\_\_\_\_ **\_**\_\_\_  If Yes, please state type of drug and length of recovery time: |

Services Requested:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Info obtained by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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