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**Trauma Recovery Center Referral Form**

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

*Jaida Richardson at* *jrichardson@astorservices.org*

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

Please check:                                                            YES             NO

|  |  |  |
| --- | --- | --- |
|  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?  |

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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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