Trauma Recovery Center Referral Form

Please return this completed form to TRC Program Director:
Jaida Richardson at jrichardson@astorservices.org

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: _____

Client Name:	D.O.B.	Gender:
Street Address:		
City:	State:	Zip:
Telephone:	Email address:	
Primary Language: Preferred Language: (if Hispanic/Latino indicate Country: _____)	Ethnicity:	Religion:
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?		

Household Members' Names	D.O.B.	M/F	School/Grade/Occupation	Relation	Ethnicity

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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