



Referral Form

Date _____

E-Mail Referrals to: rachaelwarriorfoundation@yahoo.com

* The Referral Form must be filled out by a professional

** Please note that eligibility for financial assistance related to domestic violence is determined on a case by case basis. While we strive to assist as many individuals as possible not all referrals may meet the criteria for financial support we encourage everyone in need to apply and decisions for services are made based on individual circumstances and available resources.*

**For streamlined support we recommend reaching out to our partner organizations who will facilitate the referral process. Please check on our homepage for our partners.*

Legal Name _____ DOB _____ Address _____ City _____
Zip _____ Phone Numbers: _____ Home Work _____ Cell _____

Primary Language - Client _____

Resides: Alone w/ Partner w/ Family w/ Dependents under 18 (How many? _____)

Children: Ages _____

Gender: Male Female Transgender / M Transgender / F Transgender

Abuser: Spouse Boyfriend/Girlfriend Ex-Boyfriend/Ex-Girlfriend Partner Other relationship _____

Presenting Problem

Emergency Contact:

_____ Relationship: _____ Ph: _____
_____ Email: _____

Referral Information

Referral Source: DSS Counselor Medical provider Social Worker Case Manager

Other _____ Referrer Name: _____ Title/Relationship:

_____ Agency/Hospital (if applicable):

_____ Ph: _____ Fax:

_____ Email: _____



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Our program works within our community to connect you to services to support you and your family. Discuss some of these programs and see if you might be interested in their services.

Employment/Vocational, Counseling Training, Drug/Alcohol Counseling, Legal Advocacy, Food/Clothing
LGBTQ Support Court Advocacy Childcare/Respite Care Sexual abuse/Assault Support Shelter Housing
Peer Group Support Financial Assistance Healthcare/Medication Transportation Parenting-Support
Other DV Education Mental Health Support _____

DV/Mental Health Safety Risk Assessment & Client Identification _____
Date _____

SAFETY RISK Safety Risk Identified ___ Yes ___ No

DV Risk positive ___ Yes ___ No

Level of DV Risk: ___ High ___ Medium ___ Low ___ N/A

Current Order of Protection ___ NO ___ Yes

Mental Health Risk positive: ___ Yes ___ No

Level of Mental Health Risk: ___ High ___ Medium ___ Low ___ N/A

Other Safety Risk: ___ Yes ___ No

Level of Other Safety Risk: ___ High ___ Medium ___ Low _

INTERVENTIONS AND DISPOSITION

Interventions implemented 911 called: _ Yes No ___

Police report Yes No

Initial Safety Plan Discussed: ___ Yes ___ No ___

Referred to DV Help Line: ___ Yes ___ No ___

Referred to DV Partner Agency: ___ Yes ___ No ___

Referred to ER or Psychiatric Hospital: ___ Yes ___ No ___

