

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 bias. 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:	Address Home Work	Cell	
Primary Language	- Client			
Resides: Alone [□ w/ Partner □ w/ Family	☐ w/ Dependents under 1	.8 (How ma	ny?)
Children: Ages				
Gender: □ Male □	☐ Female ☐ Transgender /	M □ Transgender / F □ Tra	ansgender	
Abuser: Spouse Bo	pyfriend/Girlfriend Ex-Boy	friend/Ex-Girlfriend Partne	er Other rel	ationship
Presenting Probler	m			
Emergency Contac		Nationshin		Dh
		elationship:		
Referral Informati	on			
Other		cal provider Social Worl Graphicable):		
			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 LGTBQ 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



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				g Alcohol/Drug Treatmen /AIDS-related Information
Patient Name	Date	of Birth	Patient Identification	on Number
Patient Address				
or my authorized representative, request that health info This authorization may include disclosure of information HIV/AIDS-RELATED INFORMATION only if I place my in of these types of information, and I initial the line on the With some exceptions, health information once disclose drug treatment, or mental health treatment information, other purpose without my authorization unless permitte HIV/AIDS-related information, I may contact the New Yo I have the right to revoke this authorization at any time I to the extent that action has already been taken based o Signing this authorization is voluntary. I understand tha conditional upon my authorization of this disclosure. Ho S. Name and Address of Provider or Entity to Release this D. Name and Address of Person(s) to Whom this Information. Purpose for Release of Information: All health information (written and oral), except:	n relating to ALCOHOL a litals on the appropriate box in Item 8, I specified may be re-disclosed by the recipient is prohibited to so under federal rk State Division of Hun- by writing to the provide in this authorization. It generally my treatmen wever, I do understand Information:	and DRUG TREAT! line in Item 8. Is cally authorize re y the recipient. If the from re-disclot or state law. If I I an Rights at 1-8 er listed below in I ann Rights at 1-8 er listed below in It, payment, enrol that I may be den	MENT, MENTAL HEALTH TREAT in the event the health informat clease of such information to th I am authorizing the release or ssing such information or using experience discrimination bec- 88-392-3644. This agency is re- item 5. I understand that I ma Illment in a health plan, or eligit	IMENT, and CONFIDENTIAL tion described below includes any e person(s) indicated in Item 6. If HIV/AIDS-related, alcohol or the disclosed information for any ause of the release or disclosure o sponsible for protecting my rights by revoke this authorization except bility for benefits will not be
For the following to be included, indicate the specific information to be disclosed and initial below.		Informatio	on to be Disclosed	Initials
Records from alcohol/drug treatment programs				
Clinical records from mental health programs*				
☐ HIV/AIDS-related Information				
If not the patient, name of person signing form:		10. Authority to	sign on behalf of patient:	
ll items on this form have been completed, my ques	tions about this form	have been answ	vered and I have been provi	ded a copy of the form.
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW				DATE
Fitness Statement/Signature: I have witnessed the executed and/or the patient's authoric		n and state that a	copy of the signed authorization	on was provided to the patient
STAFF PERSON'S NAME AND TITLE	SIGN	ATURE		DATE
his form may be used in place of DOH-2557 and has been approved by the lowever, this form does not require health care providers to release health companied by the required statements regarding prohibition of re-disclo	information. Alcohol/drug trea			

DOH-5032 (4/11)