REFERRAL FORM

CENTRAL IOWA TRAUMA RECOVERY CENTER

Date		Time		Completed by (staff initials)	

Patient Name	Last Name	First Name	MI
Patient Alias	Last Name	First Name	MI
SSN:		DOB:	

Referral Source	☐ Self ☐ Law Enforcement ☐ VS Agency ☐ Hospital ☐ Prosecutor/VW Coordinator ☐ Corrections ☐ Mental Health/treatment Facility ☐ School/University ☐ Other Name of Referral Agency_____ Referred by (Name & Phone #)_____

Type of Crime/Trauma	☐ Physical Assault ☐ Shooting ☐ Stabbing ☐ Sexual Assault ☐ Domestic Violence ☐ Family of Victim (homicide) ☐ Family of Victim (non-homicide) ☐ OWI ☐ Refugee/Outside US trauma (torture/war trauma) ☐ Human Trafficking ☐ Robbery/Burglary ☐ Other Crime _____				
Date of Crime		Police Report?	☐ Yes ☐ No	Jurisdiction	
Case Number		Investigating Officer/Ph#			

Does this person have a TBI from the referring incident	☐ Yes ☐ No	Victim of Crime & TBI	☐ Yes ☐ No

Gender	☐ Female ☐ Male ☐ Intersex ☐ MtF Female ☐ FtM Male

Sexual Orientation	☐ Gay/Lesbian ☐ Heterosexual ☐ Bisexual ☐ Unsure/Questioning ☐ Unknown/Decline to answer

Race/Ethnicity	☐ Latinx ☐ African American ☐ Asian/Pacific Islander ☐ Native American ☐ Caucasian ☐ Mixed Race/Ethnicity ☐ Other _____ ☐ Unknown/Decline to answer

Currently on Psychotropic Medications	☐ Yes ☐ No	Which ones?	

Primary Care Physician	Last name	First name	Clinic

Eligibility & Risk Criteria	Acutely Suicidal, Psychotic &/or unable to give consent?	☐ Yes	☐ No
	Current or Previous CITRC Client?	☐ Yes	☐ No
	Currently Receiving Mental Health Services?	☐ Yes	☐ No
	Younger than Age 18	☐ Yes	☐ No
	Non-Polk County Resident?	☐ Yes	☐ No
	NOT able to receive services in English? If not, Preferred Language _____	☐ Yes	☐ No
	Does this person have family members that may want/need services?	☐ Yes	☐ No

Primary Address (include address where client will be for the next two weeks in one of these spaces)	Number, street, city, state, zip code		Here for next 2 weeks? ☐ Yes ☐ No
	☐ Own Home ☐ Relative/Friend's home ☐ Shelter ☐ Other _____	Contact Permissions:	Mail? ☐ Yes ☐ No Visit? ☐ Yes ☐ No

Other Address (include address where client will be for the next two weeks in one of these spaces)	Number, street, city, state, zip code		Here for next 2 weeks? ☐ Yes ☐ No
	☐ Own Home ☐ Relative/Friend's home ☐ Shelter ☐ Other _____	Contact Permissions:	Mail? ☐ Yes ☐ No Visit? ☐ Yes ☐ No
Primary Phone Number	(__ __ __) __ __ __-__ __ __ __	Contact Permissions ☐ Call ☐ Message	
Other Phone Number	(__ __ __) __ __ __-__ __ __ __	Contact Permissions ☐ Call ☐ Message	

Client was informed by referral agency that CITRC would be contacting them ___ Yes ____ No

By whom: _____

Intake to be completed	__ __ / __ __ / __ __ __ __	Signature Case Assigned: Supervisor