Referral to Trauma Response Program

Fax: 314-286-1730

Patient Last Name: _____ **First Name:** _____ **MI:** ____

DOB: _ _/_ _/_ _ _ _ **Age of Child:** ___ **Gender:** Male Female Non-binary/third gender

Prefer to self-describe_____ Prefer not to say

Race: American Indian/AK native AA/Black Caucasian Asian Native HI/Pacific Islander
Hispanic/Latinx Not listed _____

Insurance: _____ Medicaid Private Self-Pay

Address: _____ **Zip Code:** _____

Caregiver to Contact: _____ **Caregiver Number to Contact:** _____

Relationship to Patient: _____

Emergency Contact: _____ **Emergency Contact Number:** _____

Relationship to Patient: _____

Referring Agency: _____ **Referring Department**: _____

Referring Provider: _____**Referring Provider Number to Contact:** _____

Referral to TRP for (check all that apply):

___Pre-existing mental health needs ___Displaying new-onset symptoms
___At risk of developing MH symptoms ___Family seeks help in context of trauma

Trauma types/History for child:

Sexual abuse/assault:	Yes	No	UNK	Community/School Violence:	Yes	No	UNK
Physical abuse/assault:	Yes	No	UNK	Medical Trauma:	Yes	No	UNK
Emotional abuse:	Yes	No	UNK	Neglect :	Yes	No	UNK

Other: _____

Length of time since event or disclosure: _____

Perpetrator of abuse or assault (if applicable):

Gender: Male Female
Adult: Yes No
Relation to child: Primary relative Extended family Non-family
Perpetrator still in contact with the child: Y N UNK

Police Department or Detective involved _____

State Children's Services:

Involvement now: Yes No UNK
Involvement past: Yes No UNK
Placement out of home: Yes-Family Yes-Non-Family No UNK
Hotlined by referring provider: Yes No

Case Worker/Investigator: _____

Updated 8/19