SOT New Client Referral

Referral Source Information	
Referral Source/Agency:	Date of Referral:
Contact Name:	Phone:
Relationship to Client:	Contact Email:

Client Information			
Client Name:		DOB:	
Gender: Pronouns:		Phone:	
Address:			
Country of Origin:		Ethnicity:	
Language(s) client speaks:	Native:	Preferred:	Additional:
Client is being referred for:	☐ Medical ☐ Mental Health	☐ Legal ☐ Other: ____________________	
Please describe more about the reason(s) for which they are being referred:			
Does client have health insurance? ☐ Yes ☐ No		Type: ID #:	
Is there any additional information you feel we should know regarding this referral?			

Client Consent for Release of Information	
I, ________________________ (client) give my consent to release the above personal information to SOT. I understand that records are kept for up to 7 years, and I may have access to them at any time.	
Client Name:	*Client Signature:*
Witness Name:	*Witness Signature:*

Follow-Up WNYCST ONLY:
Receipt of Referral Date: ________________ Date Assigned to CS: ________________
First Contact Date: ________________ Contacted by: ________________________
☐ The client was unable to be reached
☐ The client declined services
☐ The client accepted services and a pre-intake is scheduled for (Date & Time): ____________________

Please email referral to dbernas@jfswny.org or fax to (716) 883-7637