

RICH 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:	<input type="checkbox"/> TST-R <input type="checkbox"/> AMP <input type="checkbox"/> PSS <input type="checkbox"/> SOT <input type="checkbox"/> Mental Health <input type="checkbox"/> Other: _____
Please describe more about the reason(s) for which they are being referred:	
Legal Status:	Health Insurance:
Is there any additional information you feel we should know regarding this referral? Please include if you have a preference between a male or female caseworker.	

Client Consent for Release of Information	
I, _____ (client) give my consent to release the above personal information to RICH. 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 RICH ONLY:	
Receipt of Referral Date: _____	Date Assigned to Program: _____
First Contact Date: _____	Contacted by: _____
<input type="checkbox"/> The client was unable to be reached <input type="checkbox"/> The client declined services <input type="checkbox"/> The client accepted services and a pre-intake is scheduled for (Date & Time): _____	