HOPE HARBOR, INC.: A SEXUAL TRAUMA RECOVERY CENTER EXTERNAL REFERRAL FOR SERVICES

LOCATION OF SERVICES

Please check the location to which you would like to make a referral:

☐913 Broadway Ave.
Bowling Green, KY 42101
270.782.5014
Fax: 270.782.5042

☐1112 S Main St.
Suite 3
Franklin, KY 42134
(Call Bowling Green Office)

☐134 N Race Street
Glasgow, KY 42141
270.659.3033

☐252 N. Main St.
Russellville, KY 42276
(Call Bowling Green Office)

REFERRING AGENCY INFORMATION

Date: ______________ **Agency:** ____________________________
Phone: ______________ **Representative:** ____________________________

CLIENT CONTACT INFORMATION

Name of Client: ___________________ **Address:** __________________________-
Age & Date of Birth: _____________________________ **(include zip)** ________________________
Legal Guardian: _____________________________ **Phone:** ________________________
Contact person (if client is a child): _________ **County:** __________
Contact person's relationship to child: ____
Home Phone: ______________ ☐ **Okay to leave message?** **Former Hope Harbor Client**
Cell Phone: ___________________ ☐ **Okay to leave message?** **Yes**_______ **No**________

CASE TYPE

Please check all that apply.

CHILD VICTIM
☐ **Rape**
☐ **Child Sexual Abuse/Incest**

ADULT VICTIM
☐ **Rape**
☐ **Adult Molested as Child**
☐ **Other Sexual Assault**

OTHER
☐ **Non- Offending Parent**
☐ **Sibling of Victim**
☐ **Other:** _____________

****NO ASSESSMENTS OR INVESTIGATIONS OF SEXUAL ABUSE ARE CONDUCTED BY HOPE HARBOR, INC.**

SERVICE(S) REQUESTED

Please check all that apply.

☐ **Individual** ☐ **Group** ☐ **Couple** ☐ **Family** ☐ **Legal Advocacy**

Language: _____________________ **Disability/Accommodations:** _____________________ **RClient**__________
(Office Use Only)

RELEASE OF INFORMATION

I agree to allow the above named referring agency to release this information to Hope Harbor, Inc. for therapeutic or legal advocacy services. My signature below indicates that I wish to have a representative from Hope Harbor, Inc. contact me to arrange services for myself and/or for my dependent child. I certify that I am legally responsible for myself and/or my dependent child. [IN CASES OF CHILD REFERRALS, DOCUMENTATION OF GUARDIANSHIP/CUSTODY WILL BE REQUIRED TO INITIATE TREATMENT]. I further agree to allow a representative from the referring agency to contact Hope Harbor, Inc. to follow up on this referral to ensure that I have been contacted for services. I may terminate this release at any time I wish with a written statement to Hope Harbor, Inc. I understand that this authorization is VOLUNTARY and that I MAY REFUSE TO SIGN IT. I also understand that treatment from Hope Harbor, Inc. may not be denied if I refuse to sign this authorization. I may, at any time, contact Hope Harbor, Inc. directly to self-refer to available services.

This authorization will expire on: ____

_____________________________________ ____________________________________
Client/Guardian Signature **Date** **Referring Agency Representative** **Date**

Thank you for your referral. A representative from Hope Harbor, Inc. will respond as quickly as possible to collect and provide further information on available services.