# 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
270.598.1800

☐ 134 N Race Street
**Glasgow**, KY 42141
270.659.3033

☐ 252 N. Main St.
**Russellville**, KY 42276
270.221.8880

## 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:** _____
**Cell Phone:** _____ ☐ **Okay to leave message?** **Former Hope Harbor Client**
**Email Address:** _____ ☐ **Okay to leave message?** **Yes**_____ **No**_____

## CASE TYPE

**Please check all that apply.**

| CHILD VICTIM | ADULT VICTIM | OTHER |
|---|---|---|
| ☐ Rape | ☐ Rape | ☐ Non- Offending Parent |
| ☐ Child Sexual Abuse/Incest | ☐ Adult Molested as Child | ☐ Sibling of Victim |
| | ☐ Other Sexual Assault | ☐ 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 ☐ Secondary/Parent Education ☐ Legal Advocacy ☐ TeleHealth Services

**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.***