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 Avenue
Bowling Green, KY
270.782.5014
Fax: 270.782.5042

☐ 1112 S Main St, Suite 3
Franklin, KY
270.598.1800

☐ 134 N Race Street
Glasgow, KY
270.659.3033

☐ 252 N. Main St.
Russellville, KY
270.221.8880

REFERRING AGENCY/SOURCE INFORMATION

Date: _____ Agency: _____
Representative: _____ Representative's Phone: _____

CLIENT CONTACT INFORMATION

Name of Client: _____ Date of Birth: _____
Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs County: _____
Street: _____ City: _____ State: _____ Zip: _____
Legal Guardian: _____
Home Phone: _____ ☐ Okay to leave message
Cell Phone: _____ ☐ Okay to leave message
Email Address: _____
Emergency Contact: _____ Phone: _____

Has client ever received Hope Harbor services? ☐ Yes ☐ No When _____
Does client need special accommodations? ☐ Yes ☐ No Type _____
Preferred Language ☐ Arabic ☐ Bosnian ☐ Burmese ☐ English ☐ Spanish ☐ Not Listed _____

CASE TYPE (check all that apply) **NO ASSESSMENTS OR INVESTIGATIONS OF SEXUAL ABUSE ARE CONDUCTED BY HOPE HARBOR.

CHILD VICTIM
- ☐ Rape
- ☐ Child Sexual Abuse/Incest
- ☐ Other: _____

ADULT VICTIM
- ☐ Rape
- ☐ Adult Molested as Child
- ☐ Other: _____

SECONDARY VICTIM
- ☐ Non-Offending Parent
- ☐ Sibling of Victim
- ☐ Other: _____

SERVICE(S) REQUESTED (check all that apply)

☐ Individual Therapy ☐ Couples Therapy ☐ Family Therapy ☐ Crisis Counseling ☐ Legal Advocacy
☐ TeleHealth Services ☐ Education Services

RELEASE OF INFORMATION **RClient (office use only)** _____

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.