CODAC HEALTH • RECOVERY • WELLNESS | Trauma Recovery Center

# REFERRAL FORM

*Please work with the client/patient to obtain as much of this information as possible to assist the Trauma Recovery Center in outreaching the individual to engage in TRC services. Thank you!*

| | | | | |
|---|---|---|---|---|
| **Client Name** | Last Name | First Name | | MI |
| **Preferred Name/Nickname** | | | **Client DOB** | |
| **Entry Point** | ☐ TRC ☐ ED _____ ☐ Hospital Inpatient _____ ☐ Other _____ | | | |
| **Referral Source** | ☐ Self ☐ LE _____ ☐ Hospital _____ ☐ PCAO Victims Services ☐ CODAC ☐ Other _____ | | **Date Referred** | |
| **Referred by** | Last Name | First Name | Phone | Email | Service/Clinic/Agency |
| **Trauma Type for Referral (select all that apply)** | ☐ Sexual Assault ☐ Domestic Violence ☐ Physical Assault ☐ Stabbing ☐ Shooting ☐ Homicide ☐ Vehicular Assault ☐ Other Violent Crime ☐ Human Trafficking ☐ Refugee/Outside US Trauma (torture/war trauma/gender-based violence) | | | |
| | ☐ Primary Surv. ☐ Secondary Surv. ☐ Unknown ☐ Other _____ | | | ☐ **Occurred During Incarceration?** |
| **Date of Crime/ Trauma** | (If >3 years, must be family of homicide victim/staff with Director) | **Police Report?** ☐ Yes ☐ No | **Case Number:** | |
| **TBI from Referring Incident?** ☐ Yes ☐ No | | **ROI Completed & Attached?** ☐ Yes ☐ No | Verbal Consent Given? ☐ Yes ☐ No | |
| **Gender** | ☐ Female ☐ Male ☐ Transgender ☐ Nonbinary ☐ Other ☐ Declined to Answer | | Primary Language _____ | |
| **Race/ Ethnicity** | ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or Northern African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Multiple ☐ Other _____ ☐ Declined to Answer | | | |

| | | |
|---|---|---|
| **Eligibility & Risk Criteria** | 1. Acutely suicidal; homicidal or otherwise dangerous; has active psychosis; and/or unable to give consent? NOTES: | ☐ Yes ☐ No |
| | 2. Currently receiving mental health services? | ☐ Yes ☐ No |
| | 3. Younger than 18 years old? | ☐ Yes ☐ No |
| | 4. Pima County resident? If no, indicate county of residence: _____ | ☐ Yes ☐ No |
| | 5. Violent crime/trauma occurred in the past three years and/or client is family of homicide victim. | ☐ Yes ☐ No |

| | | | | |
|---|---|---|---|---|
| **Primary Address (where plans to be for the next 2 weeks)** | Street Address/Cross Streets/Landmark | City | State | Zip |
| | Type: ☐ Own Home ☐ Relative/Friend's Home ☐ Shelter ☐ Mail pickup only ☐ Other _____ | | | |
| | Here for next 2 weeks? ☐ Yes ☐ No | Mail OK? ☐ Yes ☐ No ☐ N/A | Visit OK? ☐ Yes ☐ No | |
| **Other Address** | Street Address/Cross Streets/Landmark | City | State | Zip |
| | Type: ☐ Own Home ☐ Relative/Friend's Home ☐ Shelter ☐ Mail pickup only ☐ Other _____ | | | |

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| | | | | |
|---|---|---|---|---|
| | Here for next 2 weeks? ☐ Yes ☐ No | | Mail OK? ☐ Yes ☐ No ☐ N/A | Visit OK? ☐ Yes ☐ No |
| **Primary Phone** | Number ( ) | | Type: ☐ Cell ☐ Home ☐ Other _____ | |
| | OK to Call? ☐ Yes ☐ No | OK to Leave Messages? ☐ Yes ☐ No | | OK to Text? ☐ Yes ☐ No |
| | OK to identify as TRC? ☐ Yes ☐ No | If no, what other identification to use: _____ | | |
| **Other Phone** | Number ( ) | | Type: ☐ Cell ☐ Home ☐ Other _____ | |
| | OK to Call? ☐ Yes ☐ No | OK to Leave Messages? ☐ Yes ☐ No | | OK to Text? ☐ Yes ☐ No |
| | OK to identify as TRC? ☐ Yes ☐ No | If no, what other identification to use: _____ | | |
| **Email** | | OK to Email? ☐ Yes ☐ No | ☐ Pref Secure Email ☐ Pref Non-secure Email | |
| **If currently in hospital, indicate hospital and location within hospital:** | | | | |

**By signing below, I give my consent for this Referral Form – and the information contained within it – to be shared with the CODAC Health, Recovery & Wellness Trauma Recovery Center for care coordination.**

| **Client Name (Printed)** | **Client Signature** | **Date** |
|---|---|---|
| | | |
| **Preparer Name (Printed)** | **Preparer Signature** | **Date** |
| | | |

*Referred patients can expect to receive a telephone call from CODAC Health, Recovery & Wellness within 48 business hours. CODAC will make three attempts to reach the patient before the referral is closed. Referring provider will be notified when patient completes first appointment or if patient does not engage in services.*

**PLEASE SCAN AND SEND THIS REFERRAL FORM VIA SECURE EMAIL OR FAX**

CODAC Trauma Recovery Center | Phone: (520) 202-1761 | 1600 N. Country Club Road
Email: TRC@codac.org | Fax: (520) 327-2992 | Tucson, AZ 85716

**FOR TRC STAFF COMPLETION ONLY:**

| | | |
|---|---|---|
| **Not evaluated by TRC staff because** | ☐ Declined Interview/Contact ☐ Discharged/Left Before Evaluation ☐ Too Ill, Confused or Unconscious<br>☐ Declined Services ☐ Clinical Caseloads Full ☐ SA/DV Consult Only ☐ Evaluated | |
| **Screening Entered in NextGen** | Date Entered: | Entered By: |