



**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		<input type="checkbox"/> TRC <input type="checkbox"/> ED _____ <input type="checkbox"/> Hospital Inpatient _____ <input type="checkbox"/> Other _____			
Referral Source		<input type="checkbox"/> Self <input type="checkbox"/> LE _____ <input type="checkbox"/> Hospital _____ <input type="checkbox"/> PCAO Victims Services <input type="checkbox"/> CODAC <input type="checkbox"/> Other _____	Date Referred		
Referred by	Last Name	First Name	Phone		
			Email		
			Service/Clinic/Agency		
Trauma Type for Referral (select all that apply)		<input type="checkbox"/> Sexual Assault <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Physical Assault <input type="checkbox"/> Stabbing <input type="checkbox"/> Shooting <input type="checkbox"/> Homicide <input type="checkbox"/> Vehicular Assault <input type="checkbox"/> Other Violent Crime <input type="checkbox"/> Human Trafficking <input type="checkbox"/> Refugee/Outside US Trauma (torture/war trauma/gender-based violence) <input type="checkbox"/> Primary Surv. <input type="checkbox"/> Secondary Surv. <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____			
		<input type="checkbox"/> Occurred During Incarceration?			
Date of Crime/Trauma		(If >3 years, must be family of homicide victim/staff with Director)	Police Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	Case Number:	
TBI from Referring Incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		ROI Completed & Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Verbal Consent Given? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Nonbinary <input type="checkbox"/> Other <input type="checkbox"/> Declined to Answer			Primary Language _____	
Race/Ethnicity	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Middle Eastern or Northern African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple <input type="checkbox"/> Other _____ <input type="checkbox"/> Declined to Answer				
SDOH	<input type="checkbox"/> Homeless/Unsheltered <input type="checkbox"/> Veteran <input type="checkbox"/> Immigrant <input type="checkbox"/> Refugee <input type="checkbox"/> Unemployed <input type="checkbox"/> LGBTQIA+				
Eligibility & Risk Criteria	1. Acutely suicidal; homicidal or otherwise dangerous; has active psychosis; and/or unable to give consent? NOTES:				<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Currently receiving mental health services?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Younger than 18 years old?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. Pima County resident? If no, indicate county of residence:				<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Violent crime/trauma occurred in the past three years and/or client is family of homicide victim.				<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Address (where plans to be for the next 2 weeks)	Street Address/Cross Streets/Landmark		City	State	Zip
	Type: <input type="checkbox"/> Own Home <input type="checkbox"/> Relative/Friend's Home <input type="checkbox"/> Shelter <input type="checkbox"/> Mail pickup only <input type="checkbox"/> Other _____				
	Here for next 2 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No		Mail OK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Visit OK? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Other Address	Street Address/Cross Streets/Landmark			City	State	Zip
	Type: <input type="checkbox"/> Own Home <input type="checkbox"/> Relative/Friend's Home <input type="checkbox"/> Shelter <input type="checkbox"/> Mail pickup only <input type="checkbox"/> Other _____					
Here for next 2 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No			Mail OK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Visit OK? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Phone	Number	()	Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other _____			
	OK to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No		OK to Leave Messages? <input type="checkbox"/> Yes <input type="checkbox"/> No		OK to Text? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	OK to identify as TRC? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what other identification to use: _____			
Other Phone	Number	()	Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Other _____			
	OK to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No		OK to Leave Messages? <input type="checkbox"/> Yes <input type="checkbox"/> No		OK to Text? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	OK to identify as TRC? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what other identification to use: _____			
Email			OK to Email? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pref Secure Email <input type="checkbox"/> 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	<input type="checkbox"/> Declined Interview/Contact <input type="checkbox"/> Discharged/Left Before Evaluation <input type="checkbox"/> Too Ill, Confused or Unconscious <input type="checkbox"/> Declined Services <input type="checkbox"/> Clinical Caseloads Full <input type="checkbox"/> SA/DV Consult Only <input type="checkbox"/> Evaluated		
Screening Entered in NextGen	Date Entered:	Entered By:	