ELEVATE REFERRAL FORM **Referral Date:** ______/______/______	PROJECT HEAL ELEVATE	**Referring Agency:** ________________________________ **Contact Name/Phone Number:** ________________________________

DEMOGRAPHIC INFORMATION		
CLIENT NAME *(Last, First)***:**		
PARENT/GUARDIAN NAME *(Last, First):*		
MRN (*Elevate Staff*):	Date of Birth: ______/_______/______	Age:
Gender Identity:	Race:	Ethnicity:
Primary Language:	Interpreter Needed: ☐ Yes ☐ No	
Address:		
Housing Status:	Resides With:	
Cell Phone:	Other Phone:	

EMERGENCY CONTACT	
Name:	Phone: (_______) -_________-____________
Relationship to Client:	

SCHOOL INFORMATION	
Name of School:	Grade:
Address of School:	IEP/504: ☐ Yes ☐ No ☐ Unknown If yes, classification:______________________________

IDENTIFIED RISK FACTORS *(check all that apply)***:**
☐ History of trauma ☐ Gang involvement (or exposure) ☐ Poor academic performance ☐ Mental health issues ☐ Truancy
☐ Substance abuse ☐ Poor social supports ☐ Exposure to violence ☐ Financial hardship ☐ Other: ______________________

REASON FOR REFERRAL
Briefly describe why client is being referred:
Briefly describe any safety concerns and/or immediate needs:
Are there currently services in place? (IIC, outpatient counseling, psychiatric treatment, etc):

Please forward this form to Kristina Vander, LCSW Elevate Clinical Program Manager at kristina.vander@hmhn.org

INCLUDE ANY RELEVANT HEALTH RECORDS WITH REFERRAL

2240 Route 33, Suite 211, Neptune City, NJ 07753
P: 732-897-8190 | F: 732-263-7917 | W: ProjectHEALNJ.org