ELEVATE REFERRAL FORM **Referral Date:** _____/_____/_____	PROJECT HEAL A community partnership to Help, Empower and Lead	**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: Relationship to Client:	Phone: (_____) -_____-_____

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:

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

INCLUDE ANY RELEVANT HEALTH RECORDS WITH REFERRAL

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