OSF SAMC Strive Trauma Recovery Center
Community Referral Form

For Referring Agencies:

Please complete this form to the best of your ability and fax to 815-671-4245, email TRCreferral@osfhealthcare.org, or call information in to our main line at 815-227-2688. Voicemail is confidential.

Referral Date: ___________________________

Client Name	
Client DOB	
Client Address	
Client Phone Number	
Referring Agency	
Agency Contact Person/Phone Number	

Date of Crime / First experience with Trauma:			
	YES	NO	Uncertain
Survivor, witness of, or family member of survivor? (Circle which one if applicable)			
Age 14 and over? If no, age________			
What is the client's zip code?			
Currently receiving counseling and/or case management services through another agency? If so, who/where?			
Have you notified the client and/or guardian of this referral?			N/A

Brief Description of Referral Needs (I.e. type of crime, symptoms, resource/case management, etc.)

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