



Family Relations Program, Inc.

Women's Survivor Services

REFERRAL INFORMATION

Date: _____ Interviewer: _____

Referred By: _____ County of Referral: _____

Person Making Referral: _____

Client Name: _____ Age: _____ Ethnic Origin: _____

Address: _____ County: _____

Phone(H): _____

(W): _____

Marital Status: _____ (Other): _____

Names and ages of other individuals living in home: _____

Offender: _____ Sex: _____ Ethnic Origin: _____

Relationship to Victim: _____

Was the abuse disclosed to an adult? _____ To Whom? _____

Was it reported to authorities? _____ Were charges brought? _____

County where offense took place: _____

Current systems involved with family: _____

Any current safety concerns? _____

Has client received therapy for abuse issues? _____

If so, with whom? _____

What prompted you to inquire about our services at this time?

*****Fax Completed Form to: 770-532-7111*****