NY SPCC
THE NEW YORK SOCIETY FOR THE PREVENTION OF CRUELTY TO CHILDREN

Trauma Recovery Program Referral

Referral Date_____

Youth Being Referred (please submit a separate form for each youth):

Name: _____Gender: _____ Age: _____ D.O.B.: _____

Is youth English speaking? Yes No If No, Primary language_____

Are siblings of this youth also being referred? Yes No If yes, please list names: _____

_____

Is the birth parent low income? : Yes No **Program only accepts low-income families*

Primary Caregiver Name: _____

Relation to Youth: _____ Email: _____

Address: _____ Borough _____Zip Code: _____

Phone: (h) _____(c) _____

Is caregiver English speaking? : Yes No If No, Primary language: _____

Birth Parent: *Please complete **only** if primary caregiver is not birth parent and birth parent will be involved in treatment.*

Name: _____ Phone:_____

Email: _____ English speaking? : Yes No If No, Primary language: _____

Trauma History: *Please list date or time frame youth experienced trauma and list **perpetrator name** and **relation to youth**.*

Psychological Maltreatment	Date(s):_____	Perpetrator:_____
Neglect	Date(s):_____	Perpetrator:_____
Physical Abuse	Date(s):_____	Perpetrator:_____
Homicide	Date(s):_____	Perpetrator:_____
Sexual Abuse	Date(s):_____	Perpetrator:_____
Domestic Violence	Date(s):_____	Perpetrator: _____
Community Violence	Date(s):_____	Perpetrator:_____
Mass Violence	Date(s):_____	Perpetrator: _____

Youth's Trauma Symptoms (brief list): _____

_____

Referral Agency: _____ Referral Source Name: _____

Phone: _____ Email: _____

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Please Email Referrals to traumareferrals@nyspcc.org Questions? Call 212.233.5500 (ext. 211)