TRAUMA RECOVERY FORM

Youth Being Referred (please submit a separate form for each youth): **Referral Date:**____________________

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: ____ 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): ____

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Referral Agency: __________________________________ Referral Source Name: _________________________________

Phone: ____ Email: ____

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Email Referrals to **traumareferrals@nyspcc.org**

Questions? Contact Program Coordinator Raydel Rijo

at 212.233.5500 (ext. 205) or 718.715.2151