

Interagency Referral Form

(Please fill out and send with customer upon referral OR EMAIL TO APPROPRIATE PARTNER-

Be sure to CC: scworksreferrals@gleamnshrc.org on all referral emails sent)

Date Referred: Click here to enter a date. Last 4 Digits of SS#: Click here to enter text. Phone#: Click here to enter text.

Customer’s Name (First, MI, Last): Click here to enter text. Email: Click here to enter text.

Alternate Contact Information: Click here to enter text.

**Referred From:**

Agency: Choose an item. Name& Title: Click here to enter text.

**Referred To:**

Agency: Choose an item. Program: Click here to enter text.

Name & Title: Click here to enter text.

**DESCRIPTION OF SERVICES YOUR CUSTOMER NEEDS:**

If an Employment Assessment and/or Plan has been completed at your agency, please document and provide client with the Assessment and/or Plan to bring or take to his/her initial visit resulting from this referral. Please add any comments that will assist the “Referred To” agency in assisting this individual:

Click here to enter text.

**DESCRIPTION OF WHEN, HOW, OR IF YOU NEED FEEDBACK ON THIS REFERRAL:**

Click here to enter text.

**Consent for Release of Information:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please Print Name

**Check One: ( ) I give my consent**

 **( ) I do not give my consent**

**I give my consent to** Choose an item. **to release my contact information, records, evaluations, and other information that will be used for the purpose of seeking assistance from** Choose an item.**.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**For Office Use Only:**

**Date received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please retain copy for client’s case file (SCAN)**

**CASE NOTE REQUIRED FOR CONTACT ATTEMPTS, APPOINTMENTS, RESULTS, ETC.**