PROVIDER REFERRAL FORM

STSM does not use email to communicate confidential client information. Please submit this referral by **MAIL to 3830 Forest Drive, Suite 201, Columbia, SC 29204** or by **FAX to 803-790-8282**.

Client Name: ____ DOB: _______________

Parent/Guardian *(if client under age 16)*: ____

Address: ____ County of Residence: ___________________

____

Telephone Number: ____ Ok to leave message? ☐YES ☐NO

Interpreter Needed? ☐NO ☐YES – Preferred Language: ____

Disability Accommodation Needed? ☐NO ☐YES – Needs: ____

STSM Services Requested: ☐Crisis ☐Individual Counseling ☐Support Group ☐Legal Advocacy

Victimizations Experienced: Include Brief Description (age at time of victimization, duration, relationship to offender). ***No further detailed information needed.***

Sexual Assault	
Adult Survivor of Childhood Sexual Abuse	
Child Sexual Abuse	
Secondary Victimization	
Sex Trafficking	
Intimate Partner Sexual Violence	
Sexual Harassment	
Stalking	
Other: _______________	

☐SIGNED CONSENT TO RELEASE/OBTAIN ATTACHED. Please contact client to schedule appointment with client.

☐NO. Signed consent is not attached. Client will contact STSM at 803-790-8208 to schedule.

Referring Provider: ____ Date: _______________

Provider Contact Information: ____