

PARTNER REFERRAL FORM FOR PARTNER SERVICES

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH STD CONTROL PROGRAM

ATTN:	DATE:
AGENCY/ORGANIZATION INFORMATIO	ON
REFERRAL SITE (NAME):	
DOC ETI EIS	☐ MCM ☐ OTL ☐ OTHER:
PERSON REFERRING (NAME & TITLE):	
PHONE NUMBER:	E-MAIL:
PARTNER INFORMATION (complete all	of the information below)
NAME (LAST, FIRST):	DOB:
GENDER: M F MTF	FTM Unk PRIMARY LANGUAGE:
MARITAL/RELATIONSHIP STATUS: \square S	☐ M ☐ Div ☐ Sep ☐ W ☐ Cohab ☐ Unk
ETHNICITY: Hispanic Not His	·
RACE (check all that apply): Am. In	
Native	e Hawaiian/ Other PI
STREET ADDRESS:CITY/TOWN	
•	STATE ZIP CODEE-MAIL:
WEBSITES/PHONE APPS:	
RISK FACTORS: MSM IDU Exchanges sex for drugs or money	
EXPOSURE TYPE(S):	nt's status Other:
Check all that apply in the table below a	and complete information about each type of exposure this
	lient Referral Form for Partner Services). Syringe/works Other, specify:
Exposure Information Sex	Syringe/works Other, specify:
Date first contact	
(mm/dd/yyyy) Date last contact	
(mm/dd/yyyy)	
Frequency (e.g., two times per week)	
COMMENTS:	

Note: Prior to sending any fax, please contact and speak directly to a Disease Intervention Specialist Supervisor - Region 1: Kimberly Williams (860) 558-9218 or Region 2: Nathan Santana (860) 748-2101. Fax completed forms, with a coversheet from your agency, to (860) 730-8380.

DO NOT E-MAIL THIS FORM.