PARTNER REFERRAL FORM FOR PARTNER SERVICES

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH STD CONTROL PROGRAM

ATTN:_____ DATE:_____

AGENCY/ORGANIZATION INFORMATION

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: ☐ S ☐ M ☐ Div ☐ Sep ☐ W ☐ Cohab ☐ Unk

ETHNICITY: ☐ Hispanic ☐ Not Hispanic

RACE (check all that apply): ☐ Am. Indian/Alaska Native Asian Black/African Am.
☐ Native Hawaiian/Other PI ☐ White ☐ Unk

STREET ADDRESS: _____

CITY/TOWN STATE ZIP CODE

PHONE NUMBERS (home/cell):_____E-MAIL: _____

WEBSITES/PHONE APPS: _____

PHYSICAL DESCRIPTION: _____

RISK FACTORS: ☐ MSM ☐ IDU ☐ Exchanges sex for drugs or money
☐ Unaware of Client's status ☐ Other: _____

EXPOSURE TYPE(S):
Check all that apply in the table below and complete information about each type of exposure this Partner had to the Client (see page 1, *Client Referral Form for Partner Services*).

Exposure Information	☐ *Sex*	☐ *Syringe/ works sharing*	☐ *Other, specify:*
Date first contact (mm/dd/yyyy)			
Date last contact (mm/dd/yyyy)			
Frequency (e.g., two times per week)			

COMMENTS: _____

_____

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***Note:* Prior to sending any fax, please contact and speak directly to a Disease Intervention Specialist - Region 1: Carlos Rodriguez (860) 306-3589 or Region 2: Alida Cuevas (959) 333-7300. Fax completed forms, with a coversheet from your agency, to (860) 730-8380.**

DO NOT E-MAIL THIS FORM.