PARTNER REFERRAL FORM

(FOR PARTNER SERVICES)

Connecticut Department of Public Health

STD Control Program

Reset Form!

ATTN: _____ Date: _____

AGENCY/ORGANIZATION INFORMATION:

REFERRAL SITE (NAME): _____

PERSON REFERRING (NAME): _____

☐ **CRCS** ☐ **EIS** ☐ **ETI** ☐ **MCM** ☐ **OTL** ☐ **OTHER:** _____

PHONE NUMBER: _____ **E-MAIL:** _____

PARTNER INFORMATION:

Last Name: _____ First Name: _____ DOB: _____

Gender: ☐ Male ☐ Female ☐ Transgender Marital/Relationship Status: _____

Ethnicity: ☐H ☐NH Race: ☐AI/AK ☐Asian ☐Black/AA ☐Native HI/PI ☐White ☐D/K

Primary Language: _____

Address: _____ Town: _____ State: _____ Zip Code: _____

Phone # (Home/Cell): _____

Work/School: _____

Websites/Phone Applications: _____ Screen Name: _____

E-mail Addresses: _____

Physical Description: _____

_____

_____

Exposure Date(s): Last: ___/ ___ / _____ First: ___ / ___ /_____ Frequency: _____

☐ Sexual Exposure ☐ Syringe Sharing Exposure

Comments: _____

_____

_____

_____

***DO NOT* E-MAIL THIS FORM!**

NOTE. **Please contact and speak directly to Terry Tierney at (860) 757-4848 or Wanda Richardson at (203) 946-7233 prior to sending any fax. Completed forms can be faxed to: Terry Tierney at 860-722-8132 or Wanda Richardson at 203-946-2950.**

Print Form

Form-CTDPH 62013HJRRS2