



# Abusive Partner Intervention Program

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## Referral Form

**\*\*\*PLEASE EMAIL THIS FORM TO ksullivan@nyctasc.org\*\*\***

Date: \_\_\_\_\_

Person being referred: \_\_\_\_\_

Address: \_\_\_\_\_

Street \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone#: \_\_\_\_\_

DOB: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Language: ( ) English ( ) Spanish ( ) Other: \_\_\_\_\_

Sex: ( ) Male ( ) Female

Referral Source: ( ) Criminal/Supreme Court ( ) Family/Civil Court ( ) Probation ( ) Parole

( ) Other: \_\_\_\_\_

For Legal Purposes Fill Out Below:

NYSID: \_\_\_\_\_

Docket/Indictment/Case#: \_\_\_\_\_

Judge: \_\_\_\_\_

Court Part: \_\_\_\_\_

Next Court Date: \_\_\_\_\_

\*Length of Program (decided by the ADA/Court): ( ) 16 Weeks ( ) 26 Weeks

Person to receive reports other than the Court:

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

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Is there an order of protection in effect? ( ) Yes: \_\_\_ Full \_\_\_ Limited ( ) No ( ) Unknown

Conditions in addition to attendance: \_\_\_\_\_

**\*WILL NEED DIRs ASSOCIATED TO CLIENT IN ORDER TO COMPLETE RISK ASSESSMENT**