BENNINGTON COUNTY CHILD ADVOCACY CENTER

Referral Form

Please print clearly on the form below to the best of your ability, information on the individual being referred.

DATE OF REFERRAL

__ __ / __ __ / __ __

PERSONAL INFORMATION

Full Name :

Nickname:

Person Referring:

Date of Birth : __ __ / __ __ / __ __

Referral Phone number:

Email :

Is client aware of referral?

Gender : ☐ Male ☐ Female

Preferred Pronouns:

GROUP SELECTION

	Group	Description
☐	Sharing Our Strengths	A support group for adult survivors of child sexual abuse.
☐	Teen Circle of Support	A support group for teens ages 13-18 who have expereinced sexual abuse.
☐	Healing Together	A support group for adult survivors of sexual assault.
☐	Time For Us	A support group for female caregivers of child sexual abuse victims.

SEND REFERRAL

A : 129 Elm Street Bennington, Vermont 05201

P : 802-442-5107

E : jonna.loomis@partner.vermont.gov

THANK YOU FOR YOUR REFERRAL

We will contact your referral within one week of receipt. Communication with referral source will only take place with client consent.