



REFERRAL FORM



Life Restored SA

Restoring a Life, Restores Family, Restores Community

This form is part of the Life Restored SA (“**LRSA**”) referral program. In addition to self-referrals, we also review community referrals (e.g. Guardians, Probation Officers, School Counselors, Coaches, Pastors etc.). In order to be considered the individual being referred should be at risk of or a survivor of sexual exploitation and/or trafficking. Candidates should be between 12 – 24 years of age. Any form submissions are treated on a strictly confidential basis.

Please complete the form below and submit it to carolyn@liferestoredsa.org. If you have any questions concerning the form or the program, please call or text us at 210-740-0011 or email us at help@liferestoredsa.org.

Name of Individual Making the Referral:

Last, First

Relationship to the candidate:

(e.g. counselor, teacher, foster care parent)

Phone Number for Referring Party:

Email Address of Referring Party:

Referred By:

(e.g. Church, School, Self-Referral, Juvenile Justice Dept.)

Date of Referral to LRSA:

Name of Prospective Candidate:

Last, First Middle

D/O/B of Candidate:

Gender:

(e.g. Male, Female, Transgender, Non-Binary etc.)

Race / Ethnicity:

Primary Language Spoken:

Current Residence:

(e.g. parental home, detention center, foster-care)

Residential Address:

Candidate Phone #: _____ **Candidate Email / Social Media Handle:** _____

Is the candidate currently under probation? If yes, please specify the reason for probation & contact information for the probation officer: _____

Last Level of Education Completed by the Candidate: _____

Services Desired: Please check all that may apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Trauma Informed Counseling | <input type="checkbox"/> Group Counseling | <input type="checkbox"/> Family Counseling |
| <input type="checkbox"/> Peer to Peer Mentoring | <input type="checkbox"/> STI Testing | <input type="checkbox"/> Educational Tutoring |
| <input type="checkbox"/> Job Planning / Seeking | <input type="checkbox"/> Pregnancy Assistance | <input type="checkbox"/> Court Advocacy |
| <input type="checkbox"/> Housing Placement | | |

Is the Candidate receiving counseling or trauma informed counseling through another organization? Please specify organization providing counseling services:

Does the Candidate have an Advocate? Please select all that apply.

- Court Advocate Rape Crisis Center Advocate Military Advocate
 CASA Advocate Other: _____

Name of Advocate (Last, First)

Advocate Phone # & Email Address

Name of Legal Guardian:

Relationship of Legal Guardian to the Candidate:

Legal Guardian Phone #:

Primary Language of Legal Guardian:

Legal Guardian Address: _____
Street Number & Street Name City State Zip Code

Additional Comments: _____

Additional Concerns (e.g. known gang affiliations, high risk of being a runaway, pregnancy etc.)

LRSA thanks you for your support in helping the youth in our community. Please note that submission of the form does not guarantee placement within the program. Admission to the program will be determined on a case-by-case basis. If your candidate is in immediate need please call our offices directly in addition to submitting the form.