



Client Referral & Information Form

www.TransActiveOnline.org
503-252-3000 | services@transactiveonline.org

Date: _____ Contact Name: _____ Adult: _____ Child: _____

If adult, relationship to child: _____ Speaks English? _____ Primary Language: _____

Phone: () _____ Safe for message? _____ Give Agency Name? Yes No

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Referral Source: _____ Case Manager (if any): _____

Referral Source Phone: () _____ Case Manager Phone: _____

Checklist of Service Offerings

Youth Services
 Adult Services
 Community Education (School, Health, Other)
 Advocacy
 Legal Referral
 Medical Referral
 PAGES (Parent Access to Gender Education Support)
 FreeZone

Comments: _____

Children (in chronological order, oldest to youngest):

Name	Age	Birth Sex <i>(Male, Female, Intersex)</i>	Gender Expression <i>(Boy, Girl, Gender Fluid, Transgender, Other)</i>	School	Grade	Teacher
1.						
2.						
3.						
4.						

Who has legal custody of the child you're seeking services for?: _____

If there is a restraining order, emergency custody order, or divorce decree, would you be willing to provide TransActive with a copy? _____
Yes / No / Maybe

Note: If DHS has legal custody, we need to have permission from your caseworker to provide services to your children.

Intake Scheduled Date: _____ Time: _____ Staff: _____