Co-Response Team Referral Form

IF THIS IS AN EMERGENCY CALL 911- THIS REFERRAL IS NOT A SUBSITUTE FOR 911

Name: *First:* *Middle:* *Last:*

A/K/A-Nicknames:

Date of Birth:

Current Address, if any:

Current Whereabouts:
(Where is the person, if known, right now, for example jail, hospital, police custody, street, etc. Please be very specific, for example 125th Metro North Station):

Known Hangouts:

Gender:

Race:

Medicaid#: CARES#:

Reason for Referral/Incidents

Date	Time	Description	Outcome

Referring Entity Primary Contact(s)

Name	***Telephone***	***Email***	***Relationship***

Other Important Contacts

Name	***Telephone***	***Email***	***Relationship***

Other Info:

To Submit: Either call the Co-Response Team Triage desk Between 11-5pm Monday-Friday (646) 610-5877 or email this form to CRTNYC@health.nyc.gov

IF THIS IS AN EMERGENCY CALL 911- THIS REFERRAL IS NOT A SUBSITUTE FOR 911

Co-Response Team Referral Form

IF THIS IS AN EMERGENCY CALL 911- THIS REFERRAL IS NOT A SUBSITUTE FOR 911

To Submit: Either call the Co-Response Team Triage desk Between 11-5pm Monday-Friday (646) 610-5877 or email this form to CRTNYC@health.nyc.gov

IF THIS IS AN EMERGENCY CALL 911- THIS REFERRAL IS NOT A SUBSITUTE FOR 911