The CENTER for VICTIMS of TORTURE
Restoring the Dignity of the Human Spirit

Main Office: 470-545-2776
Fax: 678-615-3141
www.cvt.org

REFERRAL FOR CVT SERVICES

Please complete form and submit via fax or in person **ONLY*

CLIENT INFORMATION	
Referral Date:	**Referral Source Info:**
Name:	
Date of Birth:	
Gender:	
Race/Ethnicity:	
Languages Spoken:	**Interpreter Needed:** ☐ **Yes** ☐ **No**
Country of Origin:	
U.S. Date of Arrival:	
Family Size:	
INSURANCE INFORMATION	
Social Security Number:	
Insurance Type:	
Insurance Number:	
CLIENT CONTACT INFORMATION	
Address:	
Phone Number:	
Best time to call: ☐ **Morning** ☐ **Afternoon**	
Can CVT leave a voicemail: ☐ **Yes** ☐ **No**	
Does the client have special needs (e.g. transportation or scheduling restrictions):	
Did client (If minor, parent/guardian) consent to referral?	
REASON FOR REFERRAL	
Presenting Problems:	