

County of Santa Clara

Office of the County Executive Dispute Resolution Program

2310 North First Street, Suite 104
San Jose, CA 95131
(408) 792.2314 FAX: (408) 297.2463



REFERRAL FORM

Dispute Resolution Program Services
Mediation & Conciliation

Court or Agency Case #	Date Referred / /	Date Received / /	OHR #
PARTY 1			
First Name	M.I.	Last Name(s)	
Address	City	State	Zip Code
Day Phone # () <input type="checkbox"/> work <input type="checkbox"/> home	Evening Phone # () <input type="checkbox"/> work <input type="checkbox"/> home	Message Phone # ()	
PARTY 2			
First Name	M.I.	Last Name(s)	
Address	City	State	Zip Code
Day Phone # () <input type="checkbox"/> work <input type="checkbox"/> home	Evening Phone # () <input type="checkbox"/> work <input type="checkbox"/> home	Message # ()	
REFERRAL INFORMATION			
Program, Court, Agency Making Referral			Phone #
First Name of Person Referring	M.I.	Last Name	Phone #
Type of Case	Response Needed by:	Response to be Sent to Whom:	
1. Is another agency involved? <input type="checkbox"/> No <input type="checkbox"/> Yes, Agency Name _____			
2. Do the Parties know a referral was made? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. Outline of problem _____			
4. List what needs to be resolved _____			
5. RO? <input type="checkbox"/> No <input type="checkbox"/> Yes, In effect until ____/____/____ TRO? <input type="checkbox"/> No <input type="checkbox"/> Yes, In effect until ____/____/____			
Printed Name and Signature of Person Referring:			Date: / /