

****OPTIONAL INFORMATION****

What languages, other than English, do you speak? _____

Which train and bus stops are near your offices? _____

Any specific directions? _____

Have you worked/do you work with South Asian Women? Yes No

In what capacity? _____

Have you worked/do you work with issues of domestic violence? Yes No

In what capacity? _____

Would you be willing to participate in a provider education seminar on domestic violence, health,
and South Asian Women? Yes No

Would you be willing to have Sakhi/WHI brochures in your office? Yes No

Are there any additional comments you would like to make about referring someone from Sakhi to you for health services?
(Please indicate if you require any particulars, such as a written referral from Sakhi on letterhead for each patient, advance
notice, etc.)

I acknowledge that the Women’s Health Initiative at Sakhi for South Asian Women will use this information to refer health
services.

Signature: _____

Date: _____

Please fax or mail completed form to:

Sakhi for South Asian Women
Women’s Health Initiative
Attn: Reema Kalra
PO Box 20208, Greeley Square Station
New York, NY, 10001
Tel #: 212.714.9153
Fax #: 212.564.8745

If you have any questions, please contact:

Name: Reema Kalra
Tel #: 212.714.9153 x109
E-mail: reema.kalra@sakhi.org

**Thank you for taking the time to fill out this form. The information you have provided will be kept confidential and will
be used by Sakhi for women that need health services.**