help · healing · hope
KIDS FIRST INC
CHILD ABUSE TREATMENT CENTER

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REFERRAL FORM

Date of Referral: _____

Child's Name: _____ **DOB:** _____
(Last) *(First)*

Gender: __M __F Race: _____ Language: _____ Foster Care: __Y __N
Primary Insurance Carrier: _____ Policy Number: _____
Secondary Insurance Carrier: _____ Policy Number: _____

Address: _____ County: _____
Daycare/School: _____ Grade: _____
Special Needs or Disabilities: _____

Primary Caregiver's Name: _____ Does caregiver have *legal* custody: __Y __N
If no, legal custodian: _____
Relationship to Child: _____ Best time to contact: _____
Home #: _____ Work #: _____ Cell #: _____
Email address: _____ DOB/Age: _____

Other Household/Family Members	**Date of Birth**	**Relationship to Child**

(continue on separate sheet if needed)

Was this referral discussed with the caregiver? __Y __N Was consent received to share this referral with our agency? __Y __N __NA
A copy of that consent included along with this referral would be much appreciated.

Referring Agency: _____ **Contact Person:** _____

Forensic Interview and Medical Services Section

Forensic Interview Requested: ___ Yes ___No **Medical Exam Requested:** ___ Yes ____No
Prior Interviews: ___ Yes ___No If yes, name of interviewing agency: _____

Allegation of Abuse: _____ Sexual Abuse _____ Physical Abuse _____ Neglect _____ Domestic Violence _____ Other
Date Allegation First Reported: _____ Date of Last Incidence (if known): _____
Alleged Perpetrator's Name: _____ DOB/Age: _____ Gender: _____
Relationship to Child: _____ Race: _____ Language: _____

Incident Notes (*MUST complete or attach report):* _____

Therapy Services Continued on Next Page

Therapy Services Section

Life Events *(please check all that apply)*:

__Community Violence
__School Violence
__Medical Problems/Diagnoses
__Caregiver/Family Mental Health
__Maternal Depression
__Other *(describe)* _____
__Not Applicable
__Grief/Loss
__Emotional Abuse
__Caregiver/Family Substance Use
__Neglect
__Fire/Hurricane/Tornado *(specify)* _____
__Domestic Violence
__Sexual Abuse/Assault
__Military Deployment
__Physical Abuse/Assault

Reason for Referral (Please provide or attach a brief narrative of the reason for referral including any known trauma history and current symptoms of either child or caregiver)**:**

_____
_____
_____
_____
_____
_____
_____
_____

(In-house use only)

Emergency Contact: _____ *Phone:*_____
*Relationship to child:*_____

Date staffed: _____Screened in for CPP____Screened in for CAC____ Screened out (reason)_____
If screened out, client referred to:_____
If accepted, case assigned to *(therapist, interviewer)*: _____
Date of first scheduled appt.:_____ LE/DSS notified of appt: _____ Referral information confirmed: _____
Notes: _____
_____