Child Advocacy

Primary Care Provider (PCP) Referral

Stephanie V. Blank Center for Safe and Healthy Children

Child advocacy center and a department of Children's at Scottish Rite Hospital

PLEASE FILL OUT COMPLETELY Date of request: ________________

Please note: PCPs are only able to request forensic medical exams.

Practice and Physician/Provider Name: ____

Are you requesting a forensic medical exam? Yes ____ No _____

Is law enforcement involved? Yes ____ No _____

Jurisdiction: ________________________ Case Number: ________________________

Is DFCS involved? Yes ____ No _____ County: _____________

If there is a suspicion of child abuse, a report to DFCS is required by law.
Report by dialing: 1-855-GA-CHILD or 1-855-422-4453
(Reporting to the SVB Center does not satisfy mandated reporting requirements)

Victim's Data

Victim's Legal Name: _______________________________ Date of Birth: __________ Age: ___

Gender: ____Male ____Female Race: _____________ Language: ________________

Victim's Address: ___________________________________ City / ZIP: ____________________

County: ____________

Parent/Legal Guardian Name: ____

Parent/Legal Guardian Date of Birth: ___________

Relation to Victim: _________________

Phone: (H) _____________ (C) ________________

Any known special needs/developmental delays?

____

____

Allegations

Sexual abuse ______ Physical abuse _______ Neglect _______

FOR SEXUAL ABUSE (Please indicate ALL that apply):

Fondling _____ Digital-vaginal _____ Digital-Anal _____

Oral-Vaginal _____ Oral-Penile ______ Penile-Vaginal _____ Penile-Anal _____

DESCRIPTION OF ALLEGED ABUSE:
For all concerns, please be specific regarding what is being reported. This will greatly assist our ability to serve clients adequately and promptly.
____
____
____
____

Date of Last Contact with Alleged Perpetrator: _________________
Location of Abuse: ____
County: ______________

Has child had a medical exam regarding allegation?
Yes ____ No _____ Date of exam: ____________
Name of physician: _____________________________
Location: ____________________________
Medical findings: ___________________________________

Has this child completed a forensic interview (FI) regarding current allegations?
Yes ____ No _____ Date of FI: ___________ Location of FI:______________________________
If yes, who conducted previous interview? _____________________

Alleged Perpetrator Information

Name: _____________________________________
Relationship to Victim: ________________________
Gender: ____Male ____ Female
Charges: ____

Age: _____ DOB: _____________
Race: __________________
Arrested: ____Yes ____No

Fax <u>completed</u> form with a copy of ***any progress notes / lab results / relevant information*** to:

404-785-3850
Attention: Intake Coordinator

Call Intake Coordinator at **404-785-3833** if you need confirmation that the faxed or emailed referral has been received.