Forensic Services Request

Stephanie V. Blank Center for Safe and Healthy Children
A Department of Children's Healthcare of Atlanta at Scottish Rite
975 Johnson Ferry Rd Suite 350 | Atlanta, GA 30342

PLEASE FILL OUT COMPLETELY

Date of Request: ________
Agency Requesting Services is: ____
Service(s) Requested: Interview Only ___ Medical Exam ___ Both ____
(INTERVIEW REQUESTS ONLY ACCEPTED BY LAW ENFORCMENT)

Detective: __________ Phone: _____________ Date of Report: ________ Date of Incident: ________
Case#: __________

DFCS Involvement? Yes ______ No _______ County: ______________
DFCS Case Manager: ________________ Office: ______________ Cell: _________________

Victim's Data:
Victim's Legal Name: ______________________ Date of Birth: __________ Age: ___
Gender: ___Male ___Female Race: ______ Language: _____________
Victim's Address: __________________ City/State/Zip: _______________ County: _________
Current Parent/Legal Guardian: ______________________________ Guardian DOB: ____________
Relation to Victim: _______________
Phone: (H) _____________ (C) ________________
Any Special Needs or Developmental Delays_______________________________
Allegations:
Sexual Abuse ____ Physical Abuse _____ Other: Please specify: _________
Date of Last Contact: _________
FOR SEXUAL ABUSE (Please indicate all that apply): Fondling _____ Digital-Vaginal _____ Digital-Anal _____
Oral-Vaginal _____ Oral-Penile _____ Penile-Vaginal ______ Penile-Anal _____ (write additional details below)

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Alleged Perpetrator Information
Name: _________________________ Age: ____ DOB: _____________ Race: ________________
Gender: ___Male ___Female Relation to victim: _________________________
Arrested: ___Yes ___No Charges: ____

Please fax completed form with a copy of your preliminary police report (LE ONLY), report/clinic notes/interview summary and all other pertinent documentation/details to 404-785-3850