

Request for Services



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 for 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 ____

Stephanie V. Blank Center for Safe and Healthy Children – REFERRAL *(continued)*

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 *(If unknown, please specify unknown or leave this section blank.)*

Name: _____

Age: ____ DOB: _____

Relationship to Victim: _____

Race: _____

Gender: ____ Male ____ Female

Arrested: ____ Yes ____ No

Charges: _____

Fax completed 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.

