Request for Services (CAC/LE/DFCS REFERRAL)

Children's Healthcare of Atlanta
The Stephanie V. Blank Center for Safe and Healthy Children

****PLEASE FILL OUT COMPLETELY****
Date of Request:_____
Service Requested: Forensic Interview & Exam ___ Interview Only ___ Medical Exam ___
Who is requesting? _____

Is Law Enforcement Involved? Yes ____ No _____ Jurisdiction: _____ Case#: _____
Detective: _____ Phone: _____ Date of Report: _____ Date of Incident: _____

Is DFCS Involved? Yes _____ No _____ County: _____
DFCS Social Worker: _____ Phone: _____

Victim's Data

Victim's Legal Name: _____ Date of Birth: _____ Age: ___
Gender: ___Male ___Female Race: _____ Language: _____
Victim's Address: _____ City/State/Zip: _____ County: _____
Parent/Legal Guardian: _____ DOB: _____
Relation to Victim: _____
Phone: (H) _____ (C) _____
Any Known Special Needs/Developmental Delays?
_____

Allegations:

Sexual Abuse ____ Physical Abuse _____ Neglect _____
Date of Last Contact: _____

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.**)**
_____
_____
_____
_____

FOR SEXUAL ABUSE (Please indicate all that apply): Fondling _____ Digital-Vaginal _____
Digital-Anal _____ Oral-Vaginal _____ Oral-Penile _____ Penile-Vaginal _____ Penile-Anal _____

Disclosure of abuse was made to whom? _____ Relation to victim? _____
Location of Abuse: _____ County: _____

Has Child had a Medical Exam regarding current allegation?
Yes __ No ____ Date of Exam: _____ Name of Physician: _____

Location: _____ Medical Findings: _____

Has this Child completed a forensic interview regarding current allegations?
Yes ___ No ____ Date of FI: _____ Location of FI: _____
Has this Child completed a forensic interview regarding previous allegtions?
Yes ___ No ____ Date of FI: _____ Location of FI: _____
If yes, who conducted previous interview(s)? _____

Alleged Perpetrator Information

Name: _____ Age: ____ DOB: _____ Race: _____
Gender: ___Male ___Female Relation to victim: _____
Arrested: ___Yes ___No Charges: _____

Is This Child Eligible for Crimes Victim Compensation Program? __ Yes ___No
IF YES: Fax/or to email the Forensic Medical Examination Law Enforcement Verification Form completely filled out and signed for the request of a medical exam if the child is ELIGIBLE FOR THE GEORGIA CRIME VICTIMS COMPENSATION PROGRAM.

Please fax completed form with a copy any reports/relevant information to: 404-785-3850
Attention: Intake Coordinator for MEDICAL EXAMS ONLY
Attention Family Advocate for FORENSIC INTERVIEW AND CSEC Medical exam
Referral information can also be emailed to: cpcintake@choa.org
Please call Intake Coordinator if you are in need of confirmation that the faxed/emailed referral has been received at 404-785-3833