Request for Services (PCP REFERRAL)

Children's Healthcare of Atlanta

The Stephanie V. Blank Center for Safe and Healthy Children

****PLEASE FILL OUT COMPLETELY****

Date of Request:_____

Please note, PCPs are only able to request forensic medical exams. Are you requesting a forensic medical exam? Yes ____ No _____

Who is requesting? _____

Is Law Enforcement Involved? Yes ____ No _____ Jurisdiction: _____

Is DFCS Involved? Yes _____ No _____ County: _____

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: _____

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.**)**

_____

_____

_____

_____

Disclosure of abuse was made to whom? _____ Relation to victim? _____

Location of Abuse: _____ County: _____

Has Child had a previous Medical Exam regarding 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? _____

Alleged Perpetrator Information

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

Please fax completed form with a copy any reports/relevant information to: 404-785-3850
Attention: Intake Coordinator
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