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 _____

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.