



CHILD ABUSE AND NEGLECT
PREVENTION TASK FORCE
THE FUTURE OF THE WORLD, STARTS WITH OUR CHILDREN

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PROJECT SAFE & GROWING REFERRAL FORM

Date of Referral: _____

Child's Name: _____ (Last) _____ (First) _____ DOB: _____

Gender: M F Race: _____ Language: _____ Foster Care: Y N

Address: _____ County: _____

Daycare/School: _____ Grade: _____

Special Needs or Disabilities: _____

Primary Caregiver's Name: _____ Does caregiver have legal custody: Y N
 If no, legal custodian: _____

Relationship to Child: _____ Best time to contact: _____

Home #: _____ Work #: _____ Cell #: _____

Email address: _____

Other Household/Family Members

Date of Birth

Relationship to Child

(continue on separate sheet if needed)

Was this referral discussed with the caregiver? Y N Was consent received to share this referral with our agency? Y N NA

Referring Agency: _____ Contact Person: _____

Forensic Interview and Medical Services Section

Forensic Interview Requested: Yes No Medical Exam Requested: Yes No

Prior Interviews: Yes No If yes, name of interviewing agency: _____

Allegation of Abuse: _____ Sexual Abuse _____ Physical Abuse _____ Neglect _____ Domestic Violence _____ Other

Date Allegation First Reported: _____ Date of Last Incidence (if known): _____

Alleged Perpetrator's Name: _____ DOB/Age: _____ Gender: _____

Relationship to Child: _____ Race: _____ Language: _____

Incident Notes (MUST complete or attach report): _____

Therapy Services Continued on Next Page

Therapy Services Section

Life Events (please check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Community Violence | <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> School Violence | <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Sexual Abuse/Assault |
| <input type="checkbox"/> Medical Problems/Diagnoses | <input type="checkbox"/> Caregiver/Family Substance Use | <input type="checkbox"/> Military Deployment |
| <input type="checkbox"/> Caregiver/Family Mental Health | <input type="checkbox"/> Neglect | <input type="checkbox"/> Physical Abuse/Assault |
| <input type="checkbox"/> Maternal Depression | <input type="checkbox"/> Drug Exposure | |
| <input type="checkbox"/> Other (describe) _____ | | |
| <input type="checkbox"/> Not Applicable | | |

Reason for Referral (Please provide or attach a brief narrative of the reason for referral including any known trauma history and current symptoms of either child or caregiver):

(In-house use only)

Emergency Contact: _____ Phone: _____

Relationship to child: _____

Date staffed: _____ Screened in for CPP _____ Screened in for CAC _____ Screened out (reason) _____

If screened out, client referred to: _____

If accepted, case assigned to (therapist, interviewer): _____

Date of appointment: _____ Referral information confirmed: _____

Notes: _____