



REFERRAL FORM

Revised May 16, 2017

Date of Referral: _____

Spirit Case ID # _____

Case #: _____

Spirit Person ID # _____

(For Prosecutor's Office)

(For DCP&P)

CHOOSE LOCATION FOR VISIT: 42 East Laurel Road, Suite 1100, Stratford, NJ 08084 1051 W. Sherman Avenue, Bldg. 5 Unit A, Vineland, NJ 08360**SERVICES BEING REQUESTED:**

TYPE OF MEDICAL EXAM: Alleged Sexual Abuse Alleged Physical Abuse
 Alleged Neglect/ Failure to Thrive Record Review Other Medical: _____

TYPE OF MENTAL HEALTH SERVICES:

Sexual Abuse Psychological Evaluation Psychiatric Evaluation
 Individual Therapy Group Therapy (If eligible)

PATIENT INFORMATION:

Child's Name: _____ Age: _____ DOB: _____

GENDER: Female Male**ETHNICITY:** African -American Hispanic Asian - Pacific Caucasian/White Biracial: (Specify): _____**ARE THERE ANY RELATED CASES?** NO YES WHO AND WHEN? _____**REFERRAL INFORMATION:****Referent:** _____ **Phone #:** _____ **Cell:** _____**Supervisor:** _____ **Phone #:** _____**Agency:** DCP&P ARC Prosecutor's Office Professional (Medical, Mental Health, Legal) Hospital (Name) _____ Family Member (Specify): _____ Other (Specify): _____**County or DCP&P Office in which referral originated:** DCP&P Camden North DCP&P Atlantic East DCP&P Cumberland East Atlantic Cumberland DCP&P Camden Central DCP&P Atlantic West DCP&P Cumberland West Burlington Gloucester DCP&P Camden South DCP&P Burlington East DCP&P Gloucester East Camden Salem DCP&P Camden East DCP&P Burlington West DCP&P Gloucester West Cape May DCP&P Salem Other (Please Specify): _____**Address of Referral Source:** _____**Phone Number:** () _____ **E-mail:** _____**BILLING INFORMATION:** DCP&P SAR VCCB Claim Number: _____ Date: _____ Medicaid Number: _____ Effective Date: _____ Other (e.g. Insurance, etc.) Please Specify: _____

CHILD'S CURRENT PLACEMENT:

- Single Biological Parent Both Biological Parents Adoptive Parent Step Parent
- Adult Relative (Specify Relation): _____
- Adult Non-relative (Family Friend – Specify): _____
- Foster Care Kinship Care Shelter (Specify): _____
- Therapeutic Foster Care SHSP Home

Name of Child's Primary Caretaker(s): _____

Primary Language: English Spanish Other: _____

Ethnicity: African – American Hispanic Asian – Pacific Caucasian/White

Biracial: (Specify): _____ Other: _____

Telephone: (H) _____ **(W)** _____ **(C)** _____

Address: _____

CHILD'S LEGAL GUARDIAN: (If different than above)

Name(s) _____

Address: _____

Phone # _____

IF CHILD'S BIOLOGICAL PARENTS ARE NOT IDENTIFIED ABOVE, PLEASE COMPLETE THE FOLLOWING:

Biological Mother's Name: _____

Address: _____

Phone # _____

Ethnicity: African – American Hispanic Asian – Pacific Caucasian/White

Biracial: (Specify): _____ Other: _____

Biological Father's Name: _____

Address: _____

Phone # _____

Ethnicity: African – American Hispanic Asian – Pacific Caucasian/White

Biracial: (Specify): _____ Other: _____

Number of Biological Siblings: _____

Rights of biological parents terminated? YES (MOM) YES (DAD) YES (BOTH) NO

Please List ALL Persons Currently Living In the Placement:

1. _____ Age: _____ Relationship to Child: _____
2. _____ Age: _____ Relationship to Child: _____
3. _____ Age: _____ Relationship to Child: _____
4. _____ Age: _____ Relationship to Child: _____
5. _____ Age: _____ Relationship to Child: _____

HOUSEHOLD MEMBERS: Has anyone in the household been seen by CARES (in Stratford or Vineland)?

NO YES WHO AND WHEN? _____

CURRENT ABUSE ALLEGATIONS/REASON(S) FOR REMOVAL:

If there are no current abuse allegations, skip to page 4

If there are no current or past abuse allegations, skip to page 5

First Allegation:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sex Abuse – Caretaker | <input type="checkbox"/> Child on Child – Sexual | <input type="checkbox"/> Neglect |
| <input type="checkbox"/> Sex Abuse - Non-Caretaker (Adult) | <input type="checkbox"/> Child on Child – Physical | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sex Abuse – Unknown Perp | <input type="checkbox"/> Sexually Reactive Child | <input type="checkbox"/> Maltreatment-Other |
| <input type="checkbox"/> Physical Abuse – Caretaker | <input type="checkbox"/> Mental Illness – Caretaker | <input type="checkbox"/> Incarceration - Caretaker |
| <input type="checkbox"/> Physical Abuse – Non-Caretaker | <input type="checkbox"/> Poverty/Lack of Resources | <input type="checkbox"/> Substance Abuse - Caretaker |

Alleged Perpetrator: _____ **Age:** _____

Relation to Child: Biological Parent Step Parent Adult Relative Adult Non-relative
 Sibling Peer Other: _____

Is child currently having contact with the perpetrator? Yes No

IF yes, specify type of contact: Supervised Unsupervised Remains in home

DCP&P Substantiated? Yes No Pending Date: _____

If No, reason: Pending Investigation Other (Please Specify: _____)

Legal Status:

Charged/arrested Investigation Sentenced Pending Dismissed Closed

IF MORE THAN ONE ALLEGATION CURRENTLY BEING INVESTIGATED COMPLETE SECOND ALLEGATION SECTION, OTHERWISE SKIP TO INVESTIGATION STATUS:

Second Allegation:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sex Abuse – Caretaker | <input type="checkbox"/> Child on Child – Sexual | <input type="checkbox"/> Neglect |
| <input type="checkbox"/> Sex Abuse - Non-Caretaker (Adult) | <input type="checkbox"/> Child on Child – Physical | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sex Abuse – Unknown Perp | <input type="checkbox"/> Sexually Reactive Child | <input type="checkbox"/> Maltreatment-Other |
| <input type="checkbox"/> Physical Abuse – Caretaker | <input type="checkbox"/> Mental Illness – Caretaker | <input type="checkbox"/> Incarceration - Caretaker |
| <input type="checkbox"/> Physical Abuse – Non-Caretaker | <input type="checkbox"/> Poverty/Lack of Resources | <input type="checkbox"/> Substance Abuse - Caretaker |

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DCP&P Substantiated? Yes No Pending Date: _____

If No, reason: Pending Investigation Other (Please Specify: _____)

Legal Status:

Charged/arrested Investigation Sentenced Pending Dismissed Closed

INVESTIGATION STATUS OF CURRENT ALLEGATIONS:

Original allegation (as reported to DCP&P): _____

What prompted the child's disclosure? _____

Child's specific statement/behavior (related to current allegation): _____

Date of most recent incident: _____ Date of First incident: _____
Date Received Report: _____

Number of incidents: One Multiple Unknown

Interview date(s): _____ Name of DCP&P Interviewer: _____

Name of Prosecutor's Office/Police Interviewer: _____
Phone # _____

Other interviewer: _____

Location: Prosecution Investigator DCP&P Physician Therapist
Were Sessions: Audiotaped Videotaped

Interviewer's Observations: _____

Statements of others regarding child's disclosure, etc. _____

PAST ABUSE ALLEGATIONS:

Has family had past involvement with DCP&P: Yes No or Prosecutor's Office? Yes No

IF NO PREVIOUS DCP&P INVOLVEMENT, SKIP TO BEHAVIORAL CHANGES SECTION:

IF YES, ANSWER NEXT SECTION: FIRST ALLEGATIONS

PAST ABUSE ALLEGATIONS: (Continued)

FIRST ALLEGATION:

Allegation Type:

DCP&P Substantiation:

Date:

Sex Abuse-Caretaker Yes No Pending _____
Alleged Perpetrator: _____ Relation to Child: _____

Child on Child - Sexual Yes No Pending _____
Alleged Perpetrator: _____ Relation to Child: _____

Neglect Yes No Pending _____
Alleged Perpetrator: _____ Relation to Child: _____

Sex Abuse-Non-Caretaker (Adult) Yes No Pending _____
Alleged Perpetrator: _____ Relation to Child: _____

Child on Child - Physical Yes No Pending _____
Alleged Perpetrator: _____ Relation to Child: _____

Domestic Violence Yes No Pending _____
Alleged Perpetrator: _____ Relation to Child: _____

Physical Abuse-Caretaker Yes No Pending _____
Alleged Perpetrator: _____ Relation to Child: _____

Sexually Reactive Child Yes No Pending _____
Alleged Perpetrator: _____ Relation to Child: _____

Maltreatment – Other Yes No Pending _____
Alleged Perpetrator: _____ Relation to Child: _____

BEHAVIORAL CHANGES (Please denote with a check if the child is exhibiting any behavioral problems):

Wetting Bed or Clothes Bed or Clothes Soiling Firesetting: Number of Incidents: _____
Dates: _____

Self-Mutilation: When/Where: _____

If applicable, describe: _____

Substance Use: Date(s) _____ Substance: _____

Dangerous or Acting Out Behavior (Please Specify): _____

Suicidal Behavior Current Suicidal Thoughts: Yes No

Recent Attempt: Yes No If Yes, please explain: _____ Date: _____

Past Attempts: Yes No If Yes, please explain: _____ Date: _____

Other Behavior Problems (Please Explain): _____

Is child exhibiting sexualized behavior? No Yes **If yes, please answer the following:**

Touching self excessively Towards another child (# of incidents): _____

Using an object Towards Animals

LEGAL ISSUES

Yes

No

Unknown

Please Explain (e.g., Custody Disputes, DCP&P Litigation, Family Court, Civil Suit, Financial, Criminal, etc.):

MEDICAL and DEVELOPMENTAL HISTORY

Primary Healthcare Provider: _____ **Date last seen:** _____

Address: _____ **Phone Number:** (____) _____

Any Current Medical Problems: No Yes

If Yes, please explain: _____

Current and Past Medications (Medical & Psychiatric):

NAME	DOSE	PRESCRIBED BY	WHEN STARTED/ENDED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Developmental History: Unknown Normal Milestones

Delayed Milestones (Please explain): _____

Current School or Daycare: _____ **Grade:** _____

School Classification: Yes No Child Study Team Evaluation in Progress

Is the child currently refusing to attend school? Yes No

OTHER MENTAL HEALTH SERVICES RECEIVED:

Has the child ever required Psychiatric Hospitalization: No Yes Dates: _____

What Hospital: _____

If child is currently receiving any type of mental health services, please complete the following:

Individual Therapy Group Family School Counselor In-home

Name of current therapist/counselor : _____

Name of Agency: _____ Phone Number: _____

How long has child been receiving services: _____

Problem(s) Being Addressed: _____
