Children's Center for Hope & Healing, Inc.

Referral Information for Victim Services

***(CCHH USE ONLY)* Client #** _______________

Date: _______________________ Interviewer: ______________________________

Referred By: ____ Phone # ___________________

County of Referral: _______________________________ E-mail: ___________________________

Person Calling: ____

VICTIM: ____ Gender: __________________

Age: ________ Date of Birth: __________________ Ethnic Origin: _____________________

Legal Guardian: ____ Relation to child: ________________

Caretaker (if different):___________________________________ Relation to child: ________________

Address: _____________________________________ County: _____________________________

_____________________________________ Phone: _____________________________

Other Phone: ________________________

Names & ages of siblings, other children, or individuals living in home: ___________________________

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OFFENDER: _________________________________ Age: _____ Sex: _____ Ethnic Origin:_________

Relation to Victim: ____________________________ Status (Charged?):_______________

OFFENDER: _________________________________ Age: _____ Sex:_____ Ethnic Origin:_________

Relation to Victim: _____________________________ Status (Charged?):_______________

Safety Plan (Disposition):____

Are any of these Systems Involved (indicate county and contact person if known):
District Attorney: _______________________ Juvenile/Family Court: ____________________

DFCS: __________________________________ School: ____________________________

Police/Sheriff: ____________________________ Other Therapist: ____________________

Medical Exam/Forensic Interview: ________________ Date Completed:________________

Status of parents' relationship ___________________________

Any legal concerns with family? _________ If yes, explain: __________________________________

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Brief summary of incident (s):____

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