Children's of Mississippi

Safe Center

Referral Source:

Today's Date: _____

Name: _____

County: _____

Agency: _____

Address: _____

_____

Phone: _____

Fax: _____

Mobile: _____

E-mail: _____

Patient Information:

Name: _____

Birth date: _____ Race: _____ Sex: _____

Address: _____

_____

Phone: _____

Cell phone: _____

Alternate phone: _____

Legal Guardian: _____

☐ Child is also suspected youthful offender

Basis for Referral *(attach any supporting narratives, photographs, x-rays, lab tests or records)*:

Physical signs or symptoms present now? ☐ no ☐ yes - describe _____

_____

Last incident: ☐ <72 hrs ☐ 72 hrs - 5 days ☐ 5 days - 2 wks ☐ >2 wks

Last contact with suspected perpetrator: ☐ <72 hrs ☐ 72 hrs - 5 days ☐ 5 days - 2 wks ☐ >2 wks

Seen by CAC? ☐ no ☐ yes- when & where? _____

Check all suspected conditions or events:

Physical Abuse
- ☐ Bruise(s)
- ☐ Scar(s)
- ☐ Burn(s)
- ☐ Head trauma
- ☐ Skeletal fracture(s)
- ☐ Abdominal trauma
- ☐ Medical child abuse
- ☐ Poisoning
- ☐ Death
- ☐ Unspecified physical abuse

Sexual Abuse
- ☐ Pornography
- ☐ Sexualized behavior
- ☐ Genital touching
- ☐ Oral-genital or genital-oral
- ☐ Penile- oral/vaginal/anal
- ☐ Sex transmitted infection(s)
- ☐ Pregnancy
- ☐ Unspecified sexual abuse

Neglect
- ☐ Medical
- ☐ Nutritional- Failure to thrive
- ☐ Unspecified neglect
- ☐ Foster Care Intake
- ☐ Collateral child

Suspected Perpetrator(s):

Name	Birth date	Gender	Relationship to Victim

Other agencies involved *(include CAC, Coroner, DA, DHS, Law Enforcement, Primary doctor etc.)*

Name	Phone	Agency	County

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