



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 <ul style="list-style-type: none"> • Bruise(s) • Scar(s) • Burn(s) • Head trauma • Skeletal fracture(s) • Abdominal trauma • Medical child abuse 	<ul style="list-style-type: none"> • Poisoning • Death • Unspecified physical abuse Sexual Abuse <ul style="list-style-type: none"> • Pornography • Sexualized behavior • Genital touching • Oral-genital or genital-oral 	<ul style="list-style-type: none"> • Penile- oral/vaginal/anal • Sex transmitted infection(s) • Pregnancy • Unspecified sexual abuse Neglect <ul style="list-style-type: none"> • Medical • Nutritional- Failure to thrive • Unspecified neglect 	<ul style="list-style-type: none"> • Foster Care Intake • Collateral child
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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