Julie Valentine Center Intake/ Referral Form

Client #_____
FA: _____

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JVC Staff handling intake _____ Referral Date _____

Referral Source Name _____ Agency _____

Reason for Referral ☐Sexual Abuse ☐Physical Abuse ☐Sexualized Behavior ☐Witness ☐Other _____

Services Requested ☐Forensic ☐Medical ☐Records Review ☐ Family Advocacy ☐ Other_____

Child Name _____ Nickname _____

DOB _____ Age _____ Sex _____ Race _____ SS# _____

Languages _____ Translator Needed? _____

Disabilities/Special Needs _____

School _____ Grade _____

SOVA Eligible? _____ Payment Source _____ No. _____

Who will bring child to the appointment? _____

Legal Custodian/
Parents marital status _____

If in foster care, why? _____

Primary Custodian (If not a parent, a copy of the court order will be needed regarding custody)

Name _____ Relationship _____

Address _____

Phone No. (H) _____ (W) _____ (C) _____

Mother Name _____ Language _____ Translator Needed? _____

Address _____

Phone No. (H) _____ (W) _____ (C) _____

Father Name _____ Language _____ Translator Needed? _____

Address _____

Phone No. (H) _____ (W) _____ (C) _____

Agencies Involved: **(If abuse has been disclosed by a child or family member, this must be reported to law enforcement by the referring agency prior to **any** appointment being set. Mandated reporting laws of SC require a report to law enforcement when a professional has reason to believe a child has been or may be abused.)**

Agency	Name	Phone	Fax
DSS:			
Law enforcement:			
Therapist:			
Doctor Office:			
Other:			

Allegations

DOB/Age _____ Sex _____ Race _____ Any Contact With Child? _____

Alleged Offender Name _____ Relationship to Child _____

Disclosure:

Has there been a disclosure of abuse? _____ If yes, please answer the following questions:

Who did the child disclose the abuse to initially? _____

How was the disclosure made?

What did the child disclose?

Any previous interviews (including DSS/LE and basic fact finding interviews):

Previous Services re: Allegations of Abuse (A copy of previous medical exams will be needed.)

Therapy for Sexual Abuse: ☐ Yes ☐ No Therapist: _____ Phone #: _____

Medical Exam ☐Yes ☐ No Dr: _____ Phone #: _____

Forensic Interview ☐Yes ☐ No Interviewer: _____ Phone #: _____

*** If previous exam or interview, reason for additional exam/interview: _____

_____

OFFICE USE ONLY

Forensic appt. date/time: _____ Interviewer: _____ Approved By: _____

Medical Exam appt. date/time: _____ Doctor: _____ Approved By: _____

Date of Medical Records Review _____

Legal System

Has there been an arrest? _____

Will this case go through: Family Court ☐Yes ☐ No Criminal Court ☐Yes ☐ No

If DSS is involved, please note decision due date _____

Has the case gone to court yet? _____ If no, please note any scheduled court date _____

MDT Staffing

☐ Case Staffing Date and Time: _____

People to Invite to Staffing: _____

_____

_____

Comments/Notes