

Julie Valentine Center Intake / Referral Form

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 Other _____

Child Name _____ Nickname _____

DOB: _____ Age _____ Sex _____ Race _____ SS# _____

Languages _____ Translator Needed? _____

Disabilities/Special Needs _____

School _____ Grade _____

SOVA Eligible? _____ Medicaid: Yes/No _____ If yes, # _____

Who will bring child to the appointment? _____

**Marital Status of Parents,
Custody Arrangements** _____

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	Case No.
DSS:	_____	_____	_____	_____
Law enforcement	_____	_____	_____	_____
Therapist:	_____	_____	_____	_____
Doctor Office:	_____	_____	_____	_____
Other:	_____	_____	_____	_____

Allegations: Alleged Offender _____ DOB/Age _____ Sex _____ Race _____

Relationship to Child _____ Any Contact with 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

