CAPC Intake/Referral Sheet

Please complete all sections and provide a detailed description of the reason for referral, then submit via e-mail to: capc@childrensnational.org or fax: 202-476-6997.

Child's Name: _____ **DOB**: _____ **Age**: _____ **MR:**_____

Gender: (✓) ☐**M** ☐**F** **Allegations:** ☐ **ASA** ☐ **APA** ☐ **Witness to Violence**

Guardian's Name:_____**DOB:**_____**Relationship**: _____

Confirm appointment with?_____**Phone #**:_____

Who will be bringing the child:_____**Phone #:** _____

Address: _____ Home Phone#: _____

_____ Cell #: _____

Emergency Contact:_____DOB:_____Relation: _____

Address:_____Phone#:_____

Language services needed? (✓) ❑**Yes** ❑ **No** Language:_____

Insurance:_____**ID#**: _____

Private Physician:_____ Phone #: _____

Mental health provider? (✓) ☐**Yes** ☐ **No** Reported to authorities? (✓) ☐**Yes** County:_____☐**No**

CFSA/CPS Worker's Name_____

Phone:_____Cell:_____ Email: _____

Detective's Name: _____

Phone:_____Cell:_____Email:_

Disclosure made to: (✓) **Social Worker** ☐ **Detective** ☐ **Forensic Interview** ☐

Other ☐ **No Disclosure** ☐

Summary of allegations: Concerns:

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Appt. Date: _____ Time: _____ Contact Date: _____ Time: _____