Gateway Children's Advocacy Center

Referral Date: _____ Staff Completing Initials:_____

Referral Made By:_____Referring Agency: _____

County Reviewing Case in Multidisciplinary Team(Where Incident Occurred):_____

DCBS County:_____ DCBS Person:_____

Contact Number: _____

Law Enforcement Agency:_____ Law Enforcement Person:_____

Contact Number: _____

Client Information:

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

Child's SSN:_____ Gender: Race:_____

Current Address:_____

Child Living With:_____ Relationship to Child:_____

Does this person have legal custody? If no, then Legal Guardian:_____

Contact Number: _____

Does the child have any disabilities? _____

Is this a Human Trafficking and Exploitation Case? Has this child been involved in any prostitution?

Services Requested

☐ Forensic Interview Date:_____ Time:_____ Interpreter Needed?

☐ Medical Exam Date:_____ Time:_____ Language: _____

☐ Counseling Date:_____ Time:_____

☐ Hosted Interview Date:_____ Time:_____

Reason for Referral / Allegations [Attach DCBS 115 or Police Report if available]:

Alleged Perpetrator Information

Name:_____ Age:_____ Race:_____ Gender: Relationship to Victim:_____

Name:_____ Age:_____ Race:_____ Gender: Relationship to Victim:_____

Name:_____ Age:_____ Race:_____ Gender: Relationship to Victim:_____

REMINDER: Only Law Enforcement and/or DCBS Social Workers will be allowed to watch Forensic Interviews.