Gateway Children's Advocacy Center

REQUEST FOR SERVICES

Referral Date:_____Staff Completing Initials:_____

Referral Made By:_____Referring Source: _____

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

☐ DCBS:
☐ Law Enforcement:
☐ Court:
☐ Mental Health Provider:
☐ Self-Referral:

Contact Number and Email: _____

Client Information:

Client's Name:_____DOB:_____Age:_____

Client's SSN:_____Gender: _____Race:_____

Current Address:_____

Client Living With:_____Relationship to Client:_____

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

Contact Number and Email: _____

Does the client require any accommodations and/ or an interpreter? ☐ Yes ☐ No _____

Is this a Human Trafficking and Exploitation Case? ☐ Yes ☐ No Has this child been involved in any prostitution? ☐ Yes ☐ No

Services Requested:

☐ Forensic Interview Date: _____ Time: _____
☐ Hosted Interview Date:_____ Time:_____
☐ Medical Exam Date:_____ Time: _____
☐ Mental Health Date:_____ Time:_____
☐ Education Date:_____ Time:_____ Type: _____

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

Alleged Perpetrator Information

Name:_____Age:_____DOB: _____Race:_____Gender: Relationship to Victim:_____

Name:_____Age:_____DOB: _____Race:_____Gender: Relationship to Victim:_____

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

GCAC Use: Advocate: _____ Collaborate #_____ Updated: Apr 2021 by SDC