Referral Form

Please email this referral to cacreferral@gfnf4kids.org

Referrals are reviewed by CAC staff weekly to ensure timely service initiation and client/agency contact. Please contact the CAC with any questions about this form or the referral process. Referrals are to be completed by referring agency and are not intended for self-referral by caregivers. Please complete the below table in full.

Agency	Investigator/Detective/ POC	Case Number	SAO/SAAP Advocate contacted ? Y/N	Case Open Date	Current Status of Investigation pending, open, closed (date)
DCF					
LE					
SAO					
VA					

Client is being referred for the below CAC Services: (check all that apply)

☐ All CAC ☐ Advocacy ☐CAC Therapy Program ☐MDT Case Review

☐ Other: _____

Child Victim Maltreatment/Reason for Referral:

☐ Child Sexual Abuse ☐Physical Abuse ☐ DV/Household Violence TC

☐ Child on Child Sexual Abuse ☐ Medical Neglect ☐Other _____

☐ Human Trafficking

Please provide a brief narrative articulating the reason for referral: (continued Narrative on reverse)

Child fell in the pool due to a door being left open. mother found her and started CPR. Mother called 911. EMS arrived and found Viola not responding and intubated her and sent to St Mary's as a Trauma alert.

Was this child referred to Children's Home Society for services (FI or Medical)? ☐ YES ■ NO

If yes, please specify the service, date, location:

_____

Caregiver Demographic Information *(If referring solely for CAC Therapy Program and child is not in the care of biological parents, guardianship paperwork **must** accompany this referral):*

Caregiver Name: _____	Phone Number: _____

Placement Type:

☒ Biological Mom	☐ Relative	☐ Adoptive	☐ Non-Relative	☐ Foster Home	☐ Group Home

Is the child currently receiving Mental Health Services

☐ Yes, name of provider: _____

■ Not at this time

Child's Insurance Provider:_____

_____

Name of Alleged Perpetrator (AP)	
Age & DOB of AP	
AP relationship to Child Victim	
Child Victim Name	
Child Victim DOB	
Site of Abuse (jurisdiction)	
History with MDT: in this section please articulate any priors with DCF, LE or CHS/ CPT and more specifically if the client has been referred to the CAC before.	
Documentation of any cultural or language considerations that may pose a barrier to service delivery	
Narrative (continued): please provide additional information to support this referral.	

Office Use Only:
Date Received: _____ Reviewed By: _____
Referral Outcome: ☐ Accept ☐ Unable To Accept ☐ Waitlist

Tracked in CAC Referral Log by: _____
Referral Outcome Communication sent to Referring Person by: _____