

PROJECT PATHFINDER
A service of the Family Relations Program, Inc.

REFERRAL INFORMATION

Date: _____ Interviewer: _____ Client # (FRP use only)

Referred By (Name): _____ Phone: _____
Person Giving Referral Info. _____ Relationship: _____

Referral Type (agency, DFCS, etc.): _____ Referral County: _____

Is there an open DFCS case? Yes No Status: _____

Is an assessment needed? Yes No

Does child/family have Medicaid or private insurance? Yes No

Is the child/adolescent currently in foster care? Yes No A group home? Yes No

Name/s of Sexualized Child/ren or Adolescent:

1) _____ Age _____ Sex _____ Ethnic Origin _____ DOB _____	2) _____ Age _____ Sex _____ Ethnic Origin _____ DOB _____
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Legal Guardian: _____ Relationship to Child/Adoles.: _____

Caretaker: _____ Relationship to Child/Adoles.: _____

Address: _____ Phone: H _____
W _____
Other _____

County where child/adolescent resides: _____

Other people living in home: _____

Name, age, & relationship of victim/s (if applicable):

Safety Plan: _____

Charges if any: _____

Has child/adolescent been adjudicated? Yes _____ No _____

County of Jurisdiction: _____

DFCS worker?: _____ Other therapist?: _____

