Family Relations Program, Inc.
P.O. Box 907401, Gainesville, GA 30501; 770-532-6530 Fax-770-532-7111

DFACS REFERRAL FORM
VICTIM SERVICES

Please PRINT clearly using dark ink.

Date: ___________________________

(CIRCLE ONE)
Investigator/Ongoing Caseworker: _____________________________________ **Phone:** _________________________

Parent/Guardian: ____ ***Home Phone:*** ___________________________

Parent/Guardian's Relationship to Child: ________________________ ***Work Phone:*** ____________________________
Other Phone: ___________________________

Address: ____

City, State, Zip: _______________________________________

Name(s) of Child(ren) Victim(s):

____ Sex:____ Age:______ Birth Date: ____________

____ Sex:____ Age:______ Birth Date: ____________

____ Sex:____ Age:______ Birth Date: ____________

Child's Ethnic Origin: Caucasian African American Hispanic Asian Other______________

Offender's Name/Age/Ethnic Origin & Relationship to Victim: ____
____

When was the disclosure made and to whom? ____

Extent and duration of the abuse: ____
____
____
____
____

Safety Plan:____

Any behavior problems or unusual conduct at home or school?____
____
____
____
____

*******Fax Completed Form to: 770-532-7111*******