Rowan Medicine
CARES INSTITUTE

CARES Institute
Main Phone: 856-566-7036 Fax: 856-566-6108
www.caresinstitute.org

REFERRAL FORM

Rev. December 19, 2018

Date of Referral: _____ Spirit Case ID # ___ ___ ___ ___ ___ ___ ___ ___

Case #: _____ Spirit Person ID # ___ ___ ___ ___ ___ ___ ___ ___
(For Prosecutor's Office) (For DCP&P)

CHOOSE LOCATION FOR VISIT: ☐ **42 East Laurel Road, Suite 1100, Stratford, NJ 08084**
☐ **1051 W. Sherman Avenue, Bldg. 5 Unit A, Vineland, NJ 08360**

SERVICES BEING REQUESTED:

TYPE OF MEDICAL EXAM: ☐ Alleged Sexual Abuse ☐ Alleged Physical Abuse
☐ Alleged Neglect/ Failure to Thrive ☐ Record Review ☐ Other Medical:_____

TYPE OF MENTAL HEALTH SERVICES:
☐ Sexual Abuse Psychological Evaluation ☐ Psychiatric Evaluation
☐ Individual Therapy ☐ Group Therapy (If eligible)

PATIENT INFORMATION:

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

GENDER: ☐ Female ☐ Male

ETHNICITY: ☐ African -American ☐ Hispanic ☐ Asian – Pacific ☐ Caucasian/White
☐ Biracial: (Specify): _____

ARE THERE ANY RELATED CASES? ☐ **NO** ☐ **YES WHO AND WHEN?** _____
_____

REFERRAL INFORMATION:

Referent: _____ **Phone #:** _____ **Cell:** _____
Supervisor:_____ **Phone #:** _____

Agency: ☐ DCP&P ☐ ARC ☐ Prosecutor's Office
☐ Professional (Medical, Mental Health, Legal) ☐ Hospital (Name)_____
☐ Family Member (Specify): _____
☐ Other (Specify): _____

County or DCP&P Office in which referral originated:

☐ DCP&P Camden North	☐ DCP&P Atlantic East	☐ DCP&P Cumberland East	☐ Atlantic	☐ Cumberland
☐ DCP&P Camden Central	☐ DCP&P Atlantic West	☐ DCP&P Cumberland West	☐ Burlington	☐ Gloucester
☐ DCP&P Camden South	☐ DCP&P Burlington East	☐ DCP&P Gloucester East	☐ Camden	☐ Salem
☐ DCP&P Camden East	☐ DCP&P Burlington West	☐ DCP&P Gloucester West	☐ Cape May	
	☐ DCP&P Salem	☐ Other (Please Specify): _____		

Address of Referral Source:_____
Phone Number: ( ) _____ **E-mail:** _____

BILLING INFORMATION:
☐ DCP&P SAR
☐ VCCB Claim Number: _____ Date: _____
☐ Medicaid Number: _____ Effective Date: _____
☐ Other (e.g. Insurance, etc.) Please Specify: _____

CHILD'S CURRENT PLACEMENT:

☐ Single Biological Parent ☐ Both Biological Parents ☐ Adoptive Parent ☐ Step Parent

☐ Adult Relative (Specify Relation): _____

☐ Adult Non-relative (Family Friend – Specify): _____

☐ Foster Care ☐ Kinship Care ☐ Shelter (Specify):

☐ Therapeutic Foster Care ☐ SHSP Home

Name of Child's Primary Caretaker(s):_____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Ethnicity: ☐ African – American ☐ Hispanic ☐ Asian – Pacific ☐ Caucasian/White

☐ Biracial: (Specify): _____ ☐ Other: _____

Telephone: (H)_____ **(W)** _____ **(C)** _____

Address: _____

CHILD'S LEGAL GUARDIAN: (If different than above)

Name(s) _____

Address: _____

Phone # _____

IF CHILD'S BIOLOGICAL PARENTS ARE NOT IDENTIFIED ABOVE, PLEASE COMPLETE THE FOLLOWING:

Biological Mother's Name: _____

Address: _____

Phone # _____

Ethnicity: ☐ African – American ☐ Hispanic ☐ Asian – Pacific ☐ Caucasian/White

☐ Biracial: (Specify): _____ ☐ Other: _____

Biological Father's Name: _____

Address: _____

Phone # _____

Ethnicity: ☐ African – American ☐ Hispanic ☐ Asian – Pacific ☐ Caucasian/White

☐ Biracial: (Specify): _____ ☐ Other: _____

Number of Biological Siblings: _____

Rights of biological parents terminated? ☐ **YES (MOM)** ☐ **YES (DAD)** ☐ **YES (BOTH)** ☐ **NO**

Please List <u>ALL</u> Persons Currently Living In the Placement:

1. _____ Age: _____ Relationship to Child: _____
2. _____ Age: _____ Relationship to Child: _____
3. _____ Age: _____ Relationship to Child: _____
4. _____ Age: _____ Relationship to Child: _____
5. _____ Age: _____ Relationship to Child: _____

HOUSEHOLD MEMBERS: Has anyone in the household been seen by CARES (in Stratford or Vineland)?

☐ **NO** ☐ **YES WHO AND WHEN?** _____

_____

CURRENT ABUSE ALLEGATIONS/REASON(S) FOR REMOVAL:
If there are no current abuse allegations, skip to page 4
If there are no current or past abuse allegations, skip to page 5

First Allegation:

☐ **Sex Abuse – Caretaker**	☐ **Child on Child – Sexual**	☐ **Neglect**
☐ **Sex Abuse - Non-Caretaker (Adult)**	☐ **Child on Child – Physical**	☐ **Domestic Violence**
☐ **Sex Abuse – Unknown Perp**	☐ **Sexually Reactive Child**	☐ **Maltreatment-Other**
☐ **Physical Abuse – Caretaker**	☐ **Mental Illness – Caretaker**	☐ **Incarceration - Caretaker**
☐ **Physical Abuse – Non-Caretaker**	☐ **Poverty/Lack of Resources**	☐ **Substance Abuse - Caretaker**

Alleged Perpetrator: _____ **Age:** _____

Relation to Child: ☐ Biological Parent ☐ Step Parent ☐ Adult Relative ☐ Adult Non-relative ☐ Sibling ☐ Peer ☐ Other: _____

Is child currently having contact with the perpetrator? ☐ **Yes** ☐ **No**

IF yes, specify type of contact: ☐ **Supervised** ☐ **Unsupervised** ☐ **Remains in home**

DCP&P Substantiated? ☐ **Yes** ☐ **No** ☐ **Pending Date:** _____

If No, reason: ☐ Pending Investigation ☐ Other (Please Specify: _____

Legal Status:
☐ Charged/arrested ☐ Investigation ☐ Sentenced ☐ Pending ☐ Dismissed ☐ Closed

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IF MORE THAN ONE ALLEGATION CURRENTLY BEING INVESTIGATED COMPLETE SECOND ALLEGATION SECTION, OTHERWISE SKIP TO INVESTIGATION STATUS:

Second Allegation:

☐ **Sex Abuse – Caretaker**	☐ **Child on Child – Sexual**	☐ **Neglect**
☐ **Sex Abuse - Non-Caretaker (Adult)**	☐ **Child on Child – Physical**	☐ **Domestic Violence**
☐ **Sex Abuse – Unknown Perp**	☐ **Sexually Reactive Child**	☐ **Maltreatment-Other**
☐ **Physical Abuse – Caretaker**	☐ **Mental Illness – Caretaker**	☐ **Incarceration - Caretaker**
☐ **Physical Abuse – Non-Caretaker**	☐ **Poverty/Lack of Resources**	☐ **Substance Abuse - Caretaker**

Alleged Perpetrator: _____ **Age:** _____

Relation to Child: ☐ Biological Parent ☐ Step Parent ☐ Adult Relative ☐ Adult Non-relative ☐ Sibling ☐ Peer ☐ Other: _____

Is child currently having contact with the perpetrator? ☐ **Yes** ☐ **No**

IF yes, specify type of contact: ☐ **Supervised** ☐ **Unsupervised** ☐ **Remains in home**

DCP&P Substantiated? ☐ **Yes** ☐ **No** ☐ **Pending Date:** _____

If No, reason: ☐ Pending Investigation ☐ Other (Please Specify: _____

Legal Status:
☐ Charged/arrested ☐ Investigation ☐ Sentenced ☐ Pending ☐ Dismissed ☐ Closed

INVESTIGATION STATUS OF CURRENT ALLEGATIONS:

Original allegation (as reported to DCP&P):_____

_____

_____

_____

_____

What prompted the child's disclosure?_____

_____

_____

_____

_____

Child's specific statement/behavior (related to current allegation): _____

_____

_____

_____

_____

Date of most recent incident:_____ Date of First incident: _____

Date Received Report:_____

Number of incidents: ☐ One ☐ Multiple ☐ Unknown

Interview date(s): _____ Name of DCP&P Interviewer: _____

_____ _____

Name of Prosecutor's Office/Police Interviewer: _____

Phone # _____

Other interviewer: _____

Location: ☐ Prosecution Investigator ☐ DCP&P ☐ Physician ☐ Therapist

Were Sessions: ☐ Audiotaped ☐ Videotaped

Interviewer's Observations: _____

_____

_____

_____

_____

Statements of others regarding child's disclosure, etc. _____

_____

_____

_____

_____

PAST ABUSE ALLEGATIONS:

Has family had past involvement with DCP&P: ☐ Yes ☐ No or Prosecutor's Office? ☐ Yes ☐ No

IF NO PREVIOUS DCP&P INVOLVEMENT, SKIP TO BEHAVIORAL CHANGES SECTION:

IF YES, ANSWER NEXT SECTION: FIRST ALLEGATIONS

PAST ABUSE ALLEGATIONS: (Continued)
FIRST ALLEGATION:

Allegation Type: **DCP&P Substantiation:** **Date:**

☐ **Sex Abuse-Caretaker** ☐ **Yes** ☐ **No** ☐ **Pending** _____
Alleged Perpetrator: _____ **Relation to Child:** _____

☐ **Child on Child - Sexual** ☐ **Yes** ☐ **No** ☐ **Pending** _____
Alleged Perpetrator: _____ **Relation to Child:** _____

☐ **Neglect** ☐ **Yes** ☐ **No** ☐ **Pending** _____
Alleged Perpetrator: _____ **Relation to Child:** _____

☐ **Sex Abuse-Non-Caretaker (Adult)** ☐ **Yes** ☐ **No** ☐ **Pending** _____
Alleged Perpetrator: _____ **Relation to Child:** _____

☐ **Child on Child - Physical** ☐ **Yes** ☐ **No** ☐ **Pending** _____
Alleged Perpetrator: _____ **Relation to Child:** _____

☐ **Domestic Violence** ☐ **Yes** ☐ **No** ☐ **Pending** _____
Alleged Perpetrator: _____ **Relation to Child:** _____

☐ **Physical Abuse-Caretaker** ☐ **Yes** ☐ **No** ☐ **Pending** _____
Alleged Perpetrator: _____ **Relation to Child:** _____

☐ **Sexually Reactive Child** ☐ **Yes** ☐ **No** ☐ **Pending** _____
Alleged Perpetrator: _____ **Relation to Child:** _____

☐ **Maltreatment – Other** ☐ **Yes** ☐ **No** ☐ **Pending** _____
Alleged Perpetrator: _____ **Relation to Child:** _____

BEHAVIORAL CHANGES (Please denote with a check if the child is exhibiting any behavioral problems):

☐ Wetting Bed or Clothes ☐ Bed or Clothes Soiling ☐ Firesetting: Number of Incidents: _____
Dates:

☐ Self-Mutilation: When/Where: _____

If applicable, describe: _____

☐ Substance Use: Date(s) _____ Substance: _____

☐ Dangerous or Acting Out Behavior (Please Specify): _____

☐ Suicidal Behavior Current Suicidal Thoughts: ☐ Yes ☐ No

Recent Attempt: ☐ Yes ☐ No If Yes, please explain:_____ Date: _____

Past Attempts: ☐ Yes ☐ No If Yes, please explain:_____ Date: _____

☐ Other Behavior Problems (Please Explain): _____

_____

_____

Is child exhibiting sexualized behavior? ☐ No ☐ Yes **If yes, please answer the following:**
☐ Touching self excessively ☐ Towards another child (# of incidents): _____
☐ Using an object ☐ Towards Animals

LEGAL ISSUES ☐ Yes ☐ No ☐ Unknown
Please Explain (e.g., Custody Disputes, DCP&P Litigation, Family Court, Civil Suit, Financial, Criminal, etc.):

_____

_____

MEDICAL and DEVELOPMENTAL HISTORY

Primary Healthcare Provider: _____ **Date last seen:** _____

Address: _____ **Phone Number:** (____) _____

Any Current Medical Problems: ☐ No ☐ Yes
If Yes, please explain: _____

_____

Current and Past Medications (Medical & Psychiatric):

NAME DOSE PRESCRIBED BY WHEN STARTED/ENDED

_____

_____

_____

_____

Developmental History: ☐ Unknown ☐ Normal Milestones

☐ Delayed Milestones (Please explain): _____

Current School or Daycare: _____ **Grade:** _____

School Classification: ☐ Yes ☐ No ☐ Child Study Team Evaluation in Progress

Is the child currently refusing to attend school? ☐ Yes ☐ No

OTHER MENTAL HEALTH SERVICES RECEIVED:

Has the child ever required Psychiatric Hospitalization: ☐ No ☐ Yes Dates: _____

What Hospital: _____

If child is currently receiving any type of mental health services, please complete the following:

☐ Individual Therapy ☐ Group ☐ Family ☐ School Counselor ☐ In-home

Name of current therapist/counselor : _____

Name of Agency: _____ Phone Number: _____

How long has child been receiving services: _____

Problem(s) Being Addressed: _____

_____