

**RALSTON HOUSE**

**MEDICAL REFERRAL FORM**

 **(Please complete entire form. Use Unknown, Unk. or NA if information is Not Available)**

|  |  |  |
| --- | --- | --- |
| **Location: [ ]  Arvada** **[ ]  Lakewood**  | **Other:** **[ ]**  | **If Other, Location**: |
| **Date of Medical:**  | **Time:**  |
|  |
| ***CHILDREN TO RECEIVE MEDICAL EXAM(S)*** |
| **1. Child’s Name:**  | **DOB:**  | **Age:**  |
| **Child’s Gender:** | **Child resides with:**  |
|  |
| **2. Child’s Name:** | **DOB:** | **Age:** |
| **Child’s Gender:** | **Child resides with:** |
|  |
| **3. Child’s Name:** | **DOB:** | **Age:** |
| **Child’s Gender:** | **Child resides with:** |
|  |
| **4. Child’s Name:** | **DOB:** | **Age:** |
| **Child’s Gender:** | **Child resides with:** |
|  |
| **Guardian/Caregiver Name:**  | **Relationship:**  |
| **Legal Guardian: [ ]  Yes [ ]  No** |  |
| **Address:** | **Phone:** |
|  |  |
| **Guardian/Caregiver Name:**  | **Relationship:**  |
| **Same as above: [ ]**  | **Legal Guardian: [ ]  Yes [ ]  No** |
| **Address:** | **Phone:** |

|  |
| --- |
| **Other Siblings/Children in the Home:** |
| **Child’s Name:**  | **DOB:** | **Age:** |
| **1.**  |  |  |
| **2.**  |  |  |
| **3.**  |  |  |
| **4.**  |  |  |

|  |
| --- |
| **Alleged Suspect 1:**  |
| **Age:**  | **Gender:** | **Ethnicity:**  | **Relationship to Child:** |
|  |
| **Alleged Suspect 2:** |
| **Age:** | **Gender:** | **Ethnicity:** | **Relationship to Child:** |
|  |
| **Nature of concern:**  |
|  |
| **Special Needs/Considerations:**  |
|  |
| **Who is Bringing the Child for the Medical Exam?** |
|  |
| **Social Service Intake Worker:**  | **County:** |
| **Phone:**  | **CPS Referral Number:** |
|  |
| **Lead Detective:** | **Agency:** |
| **Phone:** | **CR #:** | **County:** |
|  |
| **Interviewer Name:** |
| **Victim Advocate(s):** | **Agency:** |
|  |
| **MX Professional:**  | **[ ]  Need Legal Guardian or SS Signature for MX Consent** |
|  |
| **Disclosure OR Allegation of (Mark “A” or “D”):** |
| **[ ]  Penile-Oral Penetration [ ]  Penile-Vaginal Penetration [ ]  Penile-Anal Penetration**  |
| **[ ]  Penile-Oral Contact [ ]  Penile-Vaginal Contact [ ]  Penile-Anal Contact**  |
| **[ ]  Digital-Vaginal Penetration [ ]  Digital Anal Penetration [ ]  Digital-Genital Contact**  |
| **[ ]  Digital-Anal Contact [ ]  Other (HT/At-Risk, Exposure to Porn, Contact to Breast)**  |
|  |
| **Neglect Concerns (Please Mark):** |
| **[ ]  Drug-Endangered [ ]  Lack of Nutrition [ ]  Medical Care [ ]  Other** |
|  |
| **Additional Comments:** |
|  |

 **Forms/Interview Medical Referral Form Electronic for website.docx**