

**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**