REACH Program

Intake Form

The Child Advocacy Center of Greater Rochester
1 Mount Hope Ave., Rochester, 14620
Phone: 585.935.7802 **Fax:** 585.530.2357

Date of Referral:_____

Child's Name: _____ **Birth date:**_____ **Age:**_____

Medical Record Number: ☐ Strong _____ ☐ RGH _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ non-binary/non-conforming

Race: ☐ Black ☐ White ☐ Hispanic ☐ Bi-Racial ☐ Other

Child's current address: Street:_____

City, Zip:_____

County:_____

Phone:_____ Is it okay to leave a text or voice message? Y N

Child's Legal Guardian: ☐ Mother ☐ Father ☐ Both Parents ☐ Other:_____

Mother: Name:_____

DOB:_____

Address:_____

Phone:_____ Is it okay to leave a text or voice message? Y N

Father: Name:_____

DOB:_____

Address:_____

Phone:_____ Is it okay to leave a text or voice message? Y N

Names and ages of siblings:_____

Other household occupants:_____

Concerns

Type of alleged abuse: ☐ Sexual ☐ Physical ☐ Neglect ☐ Emotional

Description of presenting problem/Interview results: _____

_____

_____

_____

_____

Has CPS report been filed? ☐ Yes ☐ No Date/Agency**:** _____

Has a Police report been filed? ☐ Yes ☐ No Date/Agency**:** _____

Has this child been interviewed? ☐ Yes ☐ No Date/By whom?**:**_____

Has this child or another family member been here in the past? Y N Name(s) and date: _____

_____

Are there other agencies and/or professionals working with the family? Y N

Agency Name Contact Person Phone & Fax Number

Medical Info

Has this child already been examined for this concern? Y N

By whom: **Date of exam:**

Results of medical exam:

Date of last physical exam:

Have labs been done? Y N Result(s):

Have x-rays been done? Y N Result(s):

Perpetrator Info

Name of alleged perpetrator: Relation to child:
Age/DOB: Race: B W H Other
Address: County:
Geographic location of alleged abuse:
Date of last contact with alleged perpetrator:

Referent Info

Referral Source: Pediatrician CPS Police CAC Other:

Name of referent:

Referent e-mail:

Address & Phone number:

Child's PCP:

Does child have health insurance? Y N **Is this a high deductible policy?** Y N Don't know

Insurance carrier & Contract number:

Special Considerations

Does the child have any developmental delays/special needs? Y N **If yes, please explain**:

Are Interpreter Services needed for the child and /or family? Y N **If yes, what language?**

Please fax completed form to (585) 530-2357