REACH Program

Intake Form

Bivona Child Advocacy Center, 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