

Referral Date	_____
Referring Person	_____
Report #	_____
Appointment Date	_____
Time	_____



Flagstaff Medical Center
Northern Arizona Healthcare

Intake Information

Safe Child Center at Flagstaff Medical Center
 FMCSafeChild.com
 Fax to 928 773-2434

Child's name _____ DOB _____

Age _____ Sex _____ Race/Tribe _____ Primary language _____

School/Grade _____

Disability: No/Yes If yes, explain _____

Referring agency _____

Contact name and phone _____

CPS/Other agency involvement _____

Contact name and phone _____

Have you contacted Victim/Witness Services? Yes No

Reason for referral:

_____ Sexual _____

_____ Physical _____

_____ Witness _____

_____ Other _____

Disclosure statements by child _____

When _____ To whom _____

In home _____ Out of home _____ Last incident _____

Suspect Name _____

Age _____ Sex _____ Relationship to child: _____

Complaints/Concerns

Physical _____

Behavioral _____

Prior forensic evaluations:

Medical _____

Interview _____



Family Status Information

Lives with _____ Transporting _____

Mother _____ Father _____

Address _____ Address _____

Phone _____ Phone _____

Parent marital/living status _____

Other significant caregiver(s)/adults _____

Sibling(s) names/ages/gender _____

Other information _____
