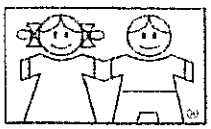

CHILDREN'S HOSPITAL

audrey hepburn care center
AT CHILDREN'S HOSPITAL NEW ORLEANS

Forensic Medical Referral

label/name

1101 Calhoun Street • New Orleans, Louisiana 70118 •www.chnola.org• (504) 896-9237 voice • (504) 896-9733 fax

Today's Date_____ *Please include copy of insurance card and send any relevant medical records*

Referral Source:	**Patient:**	**Parent:**
Name: _____	Name: _____	Name: _____
Parish: _____	Race:_____ Sex: _____ DOB:_____	Race:_____ Sex:_____ DOB:_____
Work Phone:_____	Address:_____	Address:_____
Cell Phone:_____	City: _____ State:____ Zip:_____	City: _____ State:____ Zip:_____
E-mail_____	Is the child in state custody? Y N	Work Phone: _____
Fax:_____	Primary Language other than English?	Cell Phone: _____
Referral Source:	_____	Guardian other than parent? Y N
CPS LE DA Doctor. ED?_____	Special Needs(i.e. speech delay)? Y N	_____
Other agencies involved?	Insurance _____	Primary Language other than
CPS LE ADA	Policy #_____	English? _____

Other agencies involved (Including OCS, Law Enforcement, Coroner, DA):

Contact Name	Phone & Fax Number	Agency	Parish

BASIS FOR REFERRAL: Are there any current? Injuries(Bruises/Scars/Tenderness) Signs / Symptoms What?_____

Last known incident: <72 hrs Approximate date of last known incident?_____

Last known contact with suspected perpetrator: <72 hrs Approximate date of last known contact? _____

Physical Abuse	Sexual Abuse	Neglect
Scars Burns Bruises Fractures Photos of any abuse? Y N Other: _____	Pornography STD/STI Genital Touching Oral-genital/genital oral Penile-oral/ anal/vaginal	Medical Failure to Thrive

First Disclosure - To whom?_____ **Other disclosures - To whom?** _____

Forensic Interview Completed Y N By: _____ **Disclosed? Y N**

Describe (What touched what?: including oral/anal/genital contact: body surfaces or implements used)

_____

_____

_____

_____

_____

Suspected Perpetrator(s):

Name	Birth date/Age	Sex	Relationship to Victim
		M F	
		M F	