

Referral Form

Please return form to:

Family Support Line

100 West Sixth Street

Media, PA 19063-2428

Phone: (610) 891-5237

Fax: (610) 891-0481

www.familysupportline.org

Check our web site for dates of our next group.

Referred By _____

Agency _____

Phone _____

Email _____

Date _____

NAME _____

SS# _____

SURVIVOR _____

DOB _____ Age _____

Address _____

Gender: Male Female

Primary Caretaker _____

Phone _____

Email _____

MA: YES NO

NON-OFFENDING PARENT(S) _____

Address _____

Home Phone _____

Work Phone _____

PERPETRATOR _____

Relationship to Survivor _____

Address _____

Home Phone _____

Work Phone _____

List other persons in survivor's household, ages and relationships _____

(Please complete other side)

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ABUSE HISTORY

Date of Disclosure _____

Duration of Abuse _____

Frequency of Abuse _____

Types of Abusive Interactions _____

Was violence involved? (If yes, describe) _____

CYS Case Status–Open: Yes _____ No _____ Caseworker’s Name: _____

Court Status _____

TREATMENT HISTORY

Individual ____ Family _____ Other Group _____ Hospitalization ____ Special Needs in School _____

Other _____

Current Therapist _____

Address & Phone _____

General Assessment _____

Services Requested: Parent Education Program (PATH) _____ Children’s Groups _____

Non-Offending Parent Group _____ Therapy Network _____

(For community groups only): Transportation _____

Childcare (please list ages) _____

Attendance is: Voluntary _____ Court Ordered _____