FAMILY SUPPORT LINE Referral Form

DATE	REFERRED BY	AGENCY	PHONE #	EMAIL

SURVIVOR (*If more than one, list others in table below.)*

NAME _____ SSN _____

DOB _____ AGE _____ GENDER: ☐MALE ☐FEMALE ☐TRANSGENDERED

CURRENT ADDRESS: _____

COMPLETE THE FOLLOWING IF SURVIVOR UNDER AGE 18:

PRIMARY CAREGIVER(S)	PHONE NUMBER(S)	LEGAL AUTHORITY TO CONSENT TO TREATMENT?
		YES NO NOT SURE
		YES NO NOT SURE

IMMEDIATE FAMILY MEMBERS AND ANY OTHER MEMBERS OF SURVIVOR'S HOUSEHOLD

FIRST & LAST NAME	AGE	RELATIONSHIP TO CLIENT	LIVES WITH CLIENT	FSL SERVICES NEEDED?
			YES NO	YES NO NOT SURE
			YES NO	YES NO NOT SURE
			YES NO	YES NO NOT SURE
			YES NO	YES NO NOT SURE
			YES NO	YES NO NOT SURE
			YES NO	YES NO NOT SURE

PLEASE NOTE ANY ADDITIONAL INFORMATION ABOUT CUSTODY, LIVING ARRANGEMENTS, OR CONTACTS HERE:

The following information is required for scholarship and sliding-fee scale determination:

Insurance: ☐ Medical Assistance ☐ Private_____ ☐ None

Income level: ☐ less than $9,999 ☐$10,000 to $14,999 ☐$15,000 to $19,999 ☐$20,000 to $34,999 ☐$35,000 to $49,999
☐ $50,000 to $74,999 ☐ $75,000 to $99,999 ☐ $100,000 to $199,999 ☐over $200,000

PLEASE COMPLETE OTHER SIDE OF FORM.

NATURE OF ABUSE (*CIRCLE ALL THAT APPLY. DESCRIBE "OTHER."*)

Abuser exposed self	Fondling/inappropriate touching	Oral sex	
Vaginal penetration	Vaginal intercourse	Anal penetration	Anal intercourse
Taking of sexual pictures/video	Exposure to sexually explicit materials		
Threats made by abuser	Physical abuse by abuser		
Other:			

FREQUENCY AND DURATION OF ABUSE

DATE AND CIRCUMSTANCES OF MOST RECENT DISCLOSURE/DISCOVERY

PERPETRATOR(S)

Name	Relationship to Survivor	Current Location? Contact with Survivor?

OTHER RELEVANT INFORMATION ABOUT SURVIVOR'S EXPERIENCE

CYS STATUS: ___ OPEN INVESTIGATION ____ OPEN CASE ____ NO INVOLVEMENT ____ CASE CLOSING SOON ___ NA

CASEWORKER: _____ PHONE _____

CRIMINAL: ___ OPEN INVESTIGATION ____ CHARGES PENDING ____ OPEN COURT CASE ____ CLOSED ___ NA

DeIco WAR: ___ Yes ____ Not ____ Not sure

SCHOOL: _____ GRADE _____

MENTAL HEALTH HISTORY/DIAGNOSIS

THERAPIST	**PHONE**

SERVICE(S) REQUESTED

For more information: Call 610.891.5237 or email kelly@familysupportline.org
Mail referrals to: Program Director, 100 W. 6th Street, Suite 2, Media, PA 19063 Fax referrals to: 610.891.0481