CARE FORENSIC REFERRAL FORM

Please complete the following information to make a referral for a CARE interview.
Fax this form to **LACASA Legal Intervention Team at 517-548-3034**.

DATE OF REFERRAL: _____ CASE #: _____ CPS LOG #: _____

ALLEGED VICTIM INFORMATION

Name: _____ DOB: _____ Age: _____
Sex: _____ Race: _____

Custodian's Name: _____ DOB: _____ Relationship: _____
Address: _____ Phone-primary: _____

Custodian's Name: _____ DOB: _____ Relationship: _____
Address: _____ Phone-primary: _____

Special needs of child: _____

ALLEGED PERPETRATOR INFORMATION

Name: _____ DOB: _____ Age: _____
Sex: _____ Race: _____ Relationship: _____

BRIEF DESCRIPTION OF ALLEGED ABUSE

_____

REFERING PARTY INFORMATION

Name: _____ Agency: _____ Phone: _____
Please provide days and times you are available: _____

OTHER AGENCIES

Officer's Name: _____ Department: _____ Phone: _____

CPS Worker's Name: _____ Phone: _____

IF INCIDENT OCCURRED AT SCHOOL - PROVIDE FOLLOWING INFORMATION

Name of School : _____ Address: _____
Phone: _____

Are parents/guardians aware they will be contacted by LACASA staff for scheduling? Yes ☐ No ☐

INTERNAL PURPOSES ONLY

INTERVIEW SCHEDULED
DATE: _____ TIME: _____ Location: _____