VEEP
VICTIM EDUCATION & EMPOWERMENT PROJECT

TREATMENT PROGRAM FOR CHILDREN WITH PROBLEMATIC SEXUAL BEHAVIORS

REFERRAL FORM

Date of referral: _____

Child's last name: _____ **Child's first name:** _____

Child's date of birth: _____ **Age:** _____ **Gender:** ☐ Male ☐ Female ☐ Other

Child's ethnicity: _____

REFERRAL SOURCE INFORMATION

Contact person: _____ **Agency:** _____

Office phone: _____ **Cell phone:** _____ **Email:** _____

Report made to DHS/ICW? ☐ Yes ☐ No **DHS/ICW involvement:** ☐ No ☐ Yes-Past ☐ Yes-Current

If yes, caseworker name: _____ **Primary County:** _____

Caseworker phone: _____ **Cell phone:** _____ **Fax:** _____

Caseworker email: _____

Estimated investigation closure date: _____

Is child in therapeutic foster care? ☐ No ☐ Yes – **Agency:** _____

Is law enforcement/JB/OJA involved? ☐ No ☐ Yes – **Contact person:** _____

Contact phone: _____ **Cell phone:** _____ **Fax:** _____

If there is an open investigation, please use the space below to describe the next steps of the investigation:

Caregiver notified of referral: ☐ Yes ☐ No – P*lease notify caregiver immediately.*

Is biological mother's parental rights terminated? ☐ Yes ☐ No ☐ Do not know ☐ N/A

Is biological father's parental rights terminated? ☐ Yes ☐ No ☐ Do not know ☐ N/A

Is there a plan for reunification with parents? ☐ Yes ☐ No ☐ Do not know ☐ N/A

Is there a permanency plan for the child? ☐ Yes ☐ No ☐ Do not know ☐ N/A

If necessary, then please use the space below to elaborate on the permanency plan:

OFFICE USE ONLY: ☐ **PSB** ☐ **PSB-VOCA**

CENTER ON CHILD ABUSE & NEGLECT ~ 940 NE 13th Street, 4N 4900 ~ Oklahoma City, OK 73104-5066 ~ (405) 271-8858, Fax (405) 271-2931

CAREGIVER INFORMATION

Primary caregiver's name(s): _____

Date(s) of birth: _____ **Ethnicity:** _____

Relationship to child: _____

Address: _____

Home phone: _____ **Cell phone:** _____ **Work phone:** _____

Alternate phone: _____ **Good time to call:** ☐ AM ☐ PM ☐ EVE Other: _____

Legal Guardian: ☐ Caregiver ☐ DHS ☐ Other: _____

BIOLOGICAL PARENT INFORMATION – If different from caregiver above

Parent's name: _____

Date of birth: _____ **Ethnicity:** _____

Relationship to child: _____

Address: _____

Home phone: _____ **Cell phone:** _____ **Work phone:** _____

Alternate phone: _____ **Good time to call:** ☐ AM ☐ PM ☐ EVE Other: _____

BIOLOGICAL PARENT INFORMATION – If different from caregiver above

Parent's name: _____

Date of birth: _____ **Ethnicity:** _____

Relationship to child: _____

Address: _____

Home phone: _____ **Cell phone:** _____ **Work phone:** _____

Alternate phone: _____ **Good time to call:** ☐ AM ☐ PM ☐ EVE Other: _____

OTHER PROFESSIONALS

Therapist: _____ **Phone:** _____

Psychiatrist: _____ **Phone:** _____

Systems of Care: _____ **Phone:** _____

Other: _____ **Phone:** _____

Other: _____ **Phone:** _____

REASON FOR REFERRAL – Referral Source Report

Is Referral Source a caregiver? ☐ No ☐ Yes

What are the specific sexual behaviors of concern that the child has demonstrated?

When did the last incident occur? _____ **How many incidents are known?** _____

With whom did the child have the problematic sexual behaviors?

Name	Age	Relationship to referred child	Need services related to incident?*

Has the child ever initiated sexual contact? ☐ Yes ☐ No **Was coercion used?** ☐ Yes ☐ No

Does the child have additional behavioral concerns?

***If other children noted are relatives and need services so that family therapy, reunification, and other similar factors need to be considered, then please provide details:**

CHILD VICTIMIZATION HISTORY

Has child had a victimization experience? ☐ Yes / Suspected* – Complete below (check all that apply) ☐ No

☐ Physical abuse ☐ Sexual abuse ☐ Neglect ☐ Psychological / Emotional

☐ Bullying ☐ Hate Crime ☐ School violence ☐ Kidnapping

☐ Community violence ☐ Accident ☐ War/terrorism

☐ Witnessing intimate partner violence (IPV) / Domestic violence (DV)

☐ Other: _____

Details:

Has child completed a forensic interview? ☐ Yes ☐ No, but will complete ☐ No, not needed ☐ Unsure

Date forensic interview is scheduled or completed: _____

Where was or will the forensic interview completed? _____

Concerns about child (check all that apply): ☐ No identifiable problems; child appears to be functioning well

☐ Not minding ☐ Moody / Sad ☐ Hyperactivity ☐ Sleep problems / Nightmares

☐ Self-harm ☐ Low self-esteem ☐ Anger / Aggression ☐ Bothersome memories

☐ Somatic complaints ☐ Anxiety / Fear ☐ Poor school performance ☐ Overwhelming grief

☐ Wetting / Soiling self ☐ Sexualized behavior

☐ Problematic interactions with friends ☐ Problematic interactions with caregivers

☐ Risk taking behaviors: _____

☐ Other – Explain: _____

Details:

Strengths of the child:

Email completed forms to Stephanie Edwards at stephanie.edwards@ncyvpc.org or call 618-823-7800

The Program Coordinator will contact the parent/legal guardian for additional information and, if appropriate, to schedule an intake assessment for the child.

→ A custodial caregiver must attend the intake assessment with the child. ←