Carolyn's Kaleidoscope CAC
Referral

Date of Referral: _____ Name of Person Making Referral: _____

Agency Requesting CME: _____
Investigator Name: _____ Investigator Phone #: _____

Investigator email: _____

Other Agency Involved: Y☐ N☐

Other Agency Involvement			
Agency Name	Contact Person	Contact #	Email Address

Type of Suspected Victimization: (check all that apply)

☐ Child Sexual Abuse ☐ Child Physical Abuse ☐ Neglect ☐ Emotional Abuse ☐ Witness to Violence

Other, please explain: _____

Did the child have prior medical care related to the concerns (including sexual assault medical forensic examination)
Yes☐ No☐ If yes, date of care and facility:_____

Please include any medical records

Victim Information:
Name: _____DOB: _____ Language: _____
Gender: _____ Race: _____
School/Grade: _____
Legal Guardian Name(s): _____
Sibling(s) Name(s) & age(s): _____
Current Placement: _____

Name of Non-Offending* Person Bringing the Child to the Interview: _____

*Please note this person should be supportive and believing of the child

Relationship to Victim: _____ Contact #: _____Language: _____

Name of Suspected Offender: _____ Date of Alleged Offense: _____

Suspected Offender DOB: _____ Age: _____ Relationship to Victim: _____

Please include: summary of agency involvement, prior DSS history and/or LE history for the family, or special needs

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Additional Notes

219 N. Lee St. Whiteville, NC 28472 | P: 910-356-0322 | F: 910-207-6133