PROVIDENCE INTERVENTION CENTER FOR ASSAULT AND ABUSE

Medical Referral

Date: _____ Caseworker + Contact #: _____

Client's Name: _____ Age: _____ DOB: _____

Address: _____

Caregiver's Name/Relationship (if applicable): _____

Caregiver Contact Info: _____

Type of Abuse: ___Sexual ___ Physical ___ Neglect ___ Drug Exposure ___Other

Suspected Offender: _____ Relationship: _____
Last contact: _____

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Details of Concern: _____

_____

_____

_____

Medical History (Diagnosis, injuries, illness) _____

_____

Current Medications: _____

_____

Allergies: _____
Immunization Status: _____

For Sexual Assault Concerns, we must have <u>one</u> of the following:

1) Parental signed consent for Forensic/Genital exam
2) Court order specifying Forensic/Genital Exam

Please complete and return prior to appointment with the consent for services form and guardianship documentation to: Fax:425-259-5830 or email to Sherri.Weyker@providence.org