



Child's Place

Children's Advocacy Center

Forensic Interview Intake Form

Referral Date:

Referring Agency:

Person completing form:

Phone Number:

Victim Information

Name:

Gender:

DOB:

Age:

Race/Ethnicity:

Current Address:

Who has legal custody:

Currently living with:

Relationship to victim:

Any special accommodations or concerns:

Deaf/Hard of Hearing

Blind

Cognitive/Mental Disability

Physical Disability

Other

History of Domestic Violence in the home?

Yes

No

Interpreter needed?

No

Yes

If yes, language needed

Non-offending Caregiver(s) Information

Name(s):

Race/Ethnicity:

Address:

Phone Number:

Are they aware Child's Place will be calling?

Yes

No

Who will be transporting the child?

Alleged Offender Information

Name:

Gender:

DOB:

Age:

Race/Ethnicity:

Relationship to victim:

Identified MDT Members

Law Enforcement:

Others Attending:

Child Protection:

County Attorney:



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Alleged Maltreatment Information

Primary type of maltreatment:

Additional Concerns:

Date of incident:

Location of incident:

Initial disclosure (who did the victim tell, when did the victim tell, what did the victim say?):