



Referral for PSB Program

Date of Referral

Referred by:	
First Name	Last Name
Referring Agency	Title
Phone Number	E-Mail Address

Type of Abuse:				
SXAB	PHAB	Witness SXAB	Witness PHAB	Child Fatality
NSUP	Trafficking	PSB		

Child to receive PSB Services:	
First Name	Last Name
Date of Birth	Race/Ethnicity
Primary Language	Gender

Caregiver of child to receive PSB Svcs:		
First Name	Last Name	DOB
Relationship to the Child	Primary Language	
Address	City, State ZIP	
Primary Phone	Secondary Phone	
Race/Ethnicity	Gender	
E-Mail Address	Does the child live with this caregiver?	
	Yes	No

Referral for Services

Alleged Offender (if applicable):	
First Name	Last Name
Date of Birth	Relationship to the Child
Race/Ethnicity	Gender

Case Information:			
Was a Forensic Interview completed?		Where was the FI Completed?	
Yes	No		
If no FI, please explain:		Have charges been filed?	
		Yes	No
		N/A	Unknown
Sexual Abuse Details:			
Fondling over clothes	Fondling Under Clothes	Digital Penetration – Vagina	Digital Penetration – Anus
Penile-Vaginal Penetration	Penile-Anal Penetration	Oral to Victim	Oral to Suspect
Exposure by Suspect	Voyeurism by Suspect	Exposure to Pornography	Use of Object in Abuse
Pregnancy of Victim	Hx of Abortion by Victim	Force sex act by other	One Time Occurrence
Multiple Occurrences	Sexually Acting-Out Behaviors	Other	
Physical Abuse Details:			
Failure to Thrive	Hospitalization	Abusive Head Trauma	Blunt Force Trauma
Fracture to Arm(s)	Fracture to Leg(s)	Fracture to Rib(s)	Fracture to Head
Other			

Referral for Services

Case Information:			
Did the child make a disclosure?		Was a Medical Exam completed?	
Yes	No	Yes	No
Inconclusive	Unknown	Inconclusive	Unknown
Please provide a brief summary of the case:			

DFPS Information:	
Investigator/Caseworker First Name	Investigator/Caseworker Last Name
Phone	E-Mail
Case Name	Case Number

Law Enforcement Information:	
Detective's First Name	Detective's Last Name
Phone	E-Mail
Jurisdiction/Agency	Report/Offense Number