Triangle
Family
Services

Sexual Abuse Treatment Program (SATP)
Referral Form

The Sexual Abuse Treatment Program (SATP) at Triangle Family Services provides TF-CBT for child victims of sexual abuse as well as evidenced based evaluations and treatment for children and youth with concerning sexual behaviors.

Please Note: We cannot schedule an initial appointment until all requested documentation has been received.

Date: Medicaid # NC Join # (if applicable)

Type of Referral ***(select all that apply):***

- ☐ Youth is a victim of Child Sexual Abuse
- ** ☐ Youth is engaging in sexually concerning behaviors
- ** ☐ Youth has been adjudicated in juvenile court on legal charges related to sexual behaviors
- ** ☐ Youth has pending legal charges related to sexual behaviors

****Please include a copy of any of the following materials applicable to this case: Current and previous mental health providers, psychological examinations, IEP report, CME, etc.**

Reason for Referral (and what you hope the client will gain from these services):

Client Information

Name:

Age: **DOB:**

Full Address:

Primary Phone: Other Phone: Primary Language Spoken:

Where is client currently residing? (Home, PRTF, Hospital, Etc.):

Client's School: Grade:

School Contact Person (if relevant): Position: Phone:

Special Accommodations Received? If yes, please explain.

Guardian Information

Parent/Guardian Name: Relationship to client:

Parent/Guardian Full Address (if different):

Primary Phone: Work/Other Phone:

Insurance Information

Insurance Type:

Additional Client Service Providers (e.g. Outpatient Therapist, Psychiatrist, IIH, etc.)

Contact Name: Phone:

Contact Name: Phone:

Current Medications and Dosages:

Client Allergies:

Referral Source

☐ Parent/Guardian ☐ DJJ ☐ DSS ☐ ABHC ☐ DA's Office ☐ Other

Name: Phone:

Email: Fax:

Please complete the following if referral is from the Department of Juvenile Justice:

Youth's legal status ☐ Pre-adjudication ☐ Pre-sentencing ☐ Post-conviction ☐ Post-placement

Court Counselor *(if different from referral source):* Phone:

Original charge(s):

Reduced charge(s):

Date evaluation is due in court:

*****Please include a copy of any of the following materials applicable to this case: Court Judgement or Order, Arrest Report, Witness Statement, Police Reports, Offender Statement, Victim Statement, CME, etc.***

Please MAIL or FAX referral and any included documentation to:

Triangle Family Services
3937 Western Blvd, Raleigh, NC 27606
Phone 919-821-0790 x 333 Fax 919-518-9476

nmejia@tfsnc.org

Please only send referrals and/or documentation via email if your email system uses a HIPAA compliant form of encryption.