Triangle Family Services

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| Staffed By: | Date: |
| Scheduled: | Appt.: |

# 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) _____

**Client Information**

Name: _____

Age: _____ DOB: _____

Full Address: _____City: _____State: _____ Zip: _____

Best 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: _____

School Contact Phone: _____

Client is served by an Individualized Education Plan (IEP) or 504 Plan: ☐ Yes ☐ No

Current Medications and Dosages: _____

_____

Client Allergies: _____

_____

**Insurance Information:** Insurance Type: _____ Insurance #: _____

**Guardian Information**

Parent/Guardian Name: _____ Relationship to client: _____

Parent/Guardian Full Address (if different): _____

_____

Best Phone: _____Work/Other Phone: _____ Email: _____

**Referral Source (who is completing this form)** WE WILL CONTACT FOR ADDITIONAL INFORMATION

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

Name: _____ Best Phone: _____

Email: _____ Fax: _____

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

☐ Client needs therapy (treatment)
- ☐ Client has a documented history of sexual abuse and needs treatment (TF-CBT) **and/or**
- ☐ Client has problematic sexual behaviors and needs treatment

☐ Client needs a specialized evaluation related to problematic sexual behaviors

**If you are requesting a specialized evaluation due to problematic sexual behaviors additional information is needed regarding the referral questions for the evaluation. (check all that apply)**

- ☐ The client has been adjudicated and has been court ordered to receive a psychosexual risk assessment
- ☐ An evaluation has been requested by Alliance Behavioral Health
- ☐ An evaluation has been requested by another agency -_____
- ☐ The client's sexual behaviors are of concern and caregivers/service providers are not sure if the behaviors are part of normal and natural sexual development
- ☐ The client's sexual behaviors are causing problems in their home environment
- ☐ The client's sexual behaviors are causing problems in the educational environment
- ☐ Information is needed about what type of treatment is appropriate for client's problematic sexual behaviors
- ☐ Information is needed about the type and level of supervision/monitoring that is appropriate for a client with problematic sexual behaviors
- ☐ Information is needed to document the client's need for a higher level of care (enhanced service) related to problematic 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.**

| **What do you hope the client (and their family) will gain from the services requested?** |
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| |

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

Contact Name: _____ Phone: _____

Contact Name: _____ Phone: _____

## Please MAIL or FAX referral and any included documentation to:

**Triangle Family Services. Attn: Nellie Mejia**
**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.***

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# DJJ Referrals ONLY

**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.***

**Form Revised 10/4/2017**