Children's Medical Resource Network
Intake Form

Date of Intake:

Last Name	**First Name**	**Middle Initial**	
Address	**City**	**State**	**Zip**
County (where child resides)	**Phone**		

Date of Birth (child)	**Sex**	**Race**
/ /	☐ Male ☐ Female	☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other:

☐ **Parent or** ☐ **Legal Guardian**

Last Name	**First Name**	**Middle Initial**	
Address (if different from the child)	**City**	**State**	**Zip**

Will the parent or legal guardian be accompanying the child to the exam? ☐ Yes ☐ No
If not, the proper consents need to be mailed to the parent or legal guardian, signed and brought to the exam. An exam will not be performed without the proper consents.

Nature of the referral ☐ Physical Abuse ☐ Sexual Abuse ☐ Neglect ☐ Meth

Narrative Summary of Case:

Has a hotline report been made? ☐ Yes ☐ No **DCFS Investigator (if applicable):**
If not one needs to be made prior to exam. (If referral source has enough suspicion to make an appointment for this type of evaluation, then a hotline call should be made by calling 1-800-252-2873.

Individuals/ Organization that referred patient for evaluation: **Allegation #**

Last Name (contact person)	**First Name**	**Middle Initial**	
Address	**City**	**State**	**Zip**

phone #:

Who will accompany child to exam? (Social service representative)
phone #:

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Date of Appt: Time: