MIDLANDS FAMILY & CHILD ADVOCACY CLINIC

9 MEDICAL PARK DRIVE, SUITE 420, COLUMBIA, SC 29203

Referral Form

MEDICAL EXAM ONLY

Return completed form via:
fax: 803-434-3496 or email: intakemfcac@prismahealth.org

DEMOGRAPHIC INFORMATION:

Today's Date		Case Decision Date	
Child's Name Middle Initial Mandatory if known		Sex	
Age		Race	
DOB		SSN (Full SSN if patient has Medicaid)	

Insurance: ☐ Medicaid - ID#:

☐ Private Insurance: ID#: Group #:

Subscriber Name: DOB:

Source of Payment: ☐ DSS ☐Law Enforcement ☐ Patient Insurance ☐ Self-Pay

Is child in DSS custody or foster care? ☐ Yes ☐ No

Guarantor/Parent Name (mandatory):	DOB:

Child's Address (Current)

If child in DSS custody, use County DSS office address

Street Address (include Apt. or Lot No. if known)

City State Zip County

Caregiver's Name: Phone:

Relation to Child:

Parents Address:

(If different than child's)

Developmental Delays? ☐ Yes ☐ No If yes, describe:

REFERRAL INFORMATION:

Source of Referral: ☐ DSS ☐ Law Enforcement ☐ Physician

Reason for referral:

☐ Physical Abuse	☐ Sexual Abuse	☐ Witness to Violent Crime
☐ Psychological Abuse	☐ Neglect	☐ Domestic Violence
☐ Fracture under age 1 y/o	☐ Sibling/same home	☐ Other:

Please provide as much information as possible, but do not include personal opinions:

*More space provided on last page

Has the child had a forensic interview? ☐ Yes ☐ No If yes, where and when?_____

Who will bring the child to the appointment-CANNOT be suspect **(Mandatory Information)**

Name (**mandatory**):	
Relationship to child (**mandatory**):	
Phone number (**mandatory**):	

Agency Involvement:

Law Enforcement Agency:	Incident Report #:
Investigator:	Phone:
Email:	Fax (for report):

Incident report attached: ☐ Yes ☐ No

DSS Agency:	
Case Worker (**mandatory**):	Phone (**mandatory**):
Email (**mandatory**):	Fax (**for report-mandatory**):

OTHER INFORMATION:

Medical Records Attached? ☐ Yes ☐ No

Photographs Attached? ☐ Yes ☐ No

Photos must be attached, (if applicable), if the child is referred for physical abuse

Suspect (mandatory):	DOB:
Relation to child:	Race:
Address:	

Additional space for reason(s) for referral: