



A Service of the Children's Center for Hope and Healing
Project Pathfinder is a program for children and adolescents with sexual behavior problems

REFERRAL INFORMATION

Date: _____ Interviewer: _____ Client #
(CCHH use only)

Referred By (Name): _____ Phone: _____

Referral County: _____ Is an assessment needed? ____ Yes ____ No

Is there an open DFCS case? ____ Yes ____ No Status: _____

Is the child/adolescent currently in foster care? ____ Yes ____ No A group home? ____ Yes ____ No

Name: _____ Sex _____
Age: _____ Date of Birth _____ Ethnic Origin _____

Legal Guardian: _____ Relationship to Child: _____

Caretaker: _____ Relationship to Child: _____

Address: _____ Phone: Home _____

Cell _____

Other _____

County where child/adolescent resides: _____

Other people living in home: _____

Name, age, & relationship of victim/s (if applicable):

Safety Plan: _____

Has child/adolescent been adjudicated? Yes ____ No ____

Charges if any: _____

