



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:
Person Giving Referral Info. Relationship:
Referral Type (agency, DFCS, etc.): Referral County:
Is there an open DFCS case? Yes No Status:
Is an assessment needed? Yes No
Is the child/adolescent currently in foster care? Yes No A group home? Yes No

Name/s of Child/ren or Adolescent(s) being referred for treatment in Project Pathfinder:
1) Age Sex Ethnic Origin DOB
2) Age Sex Ethnic Origin DOB

Legal Guardian: Relationship to Child/Adoles.:
Caretaker: Relationship to Child/Adoles.:

Address: Phone: H W Other

County where child/adolescent resides:

Other people living in home:

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

Safety Plan:

Charges if any:

Has child/adolescent been adjudicated? Yes No

