Appendix A

REACH Clinic
Medical Evaluation Referral
Phone: (214) 456-6919
Fax: (214) 456-6401
Email: ReachClinic@childrens.com

For internal use only:

(REACH appointment date/time)

Referral Information

Date of referral:		Referral source:	
CPS caseworker:		Caseworker phone:	
		Caseworker fax:	
Police investigator:		Investigator phone:	
		Investigator fax:	

Patient Information

Patient name:		Patient DOB and age:	
Patient address:			
Patient phone:		Language:	Select

Medical Information

Reason for referral:	Select	If 'other', describe:	
Urgent?	Select	If 'yes', why? ☐ <72 hours ☐ Other, describe:	
Name/relation of person bringing child to appt:			

Alleged perpetrator's (AP) name:			
Alleged perpetrator's relationship to child:			
Alleged perpetrator's age:			
Date(s) of abuse:		Date of last contact w/AP:	

Videotaped by forensic interviewer?	☐ No ☐ Yes	If 'no' is interview scheduled? If 'yes' when and where?	☐ No ☐ Yes
Outcry by child?	☐ No ☐ Yes	If 'no,' reason for referral: If 'yes,' to whom: ☐ Interviewer ☐ Parent ☐ Other,	
Summary of outcry:			

Type of sexual contact? *(check all that apply)*	Digital-genital ☐ Digital-anal ☐	Oral-genital ☐ Oral-anal ☐	Genital-genital ☐ Genital-anal ☐	Other ☐ describe
Ejaculation?	☐ No ☐ Yes	If 'yes' describe:		
History of bleeding?	☐ No ☐ Yes	If 'yes' describe:		
History of pain?	☐ No ☐ Yes	If 'yes' describe:		
History of discharge?	☐ No ☐ Yes	If 'yes' describe:		

Previous medical exam done?	☐ No ☐ Yes	If 'yes' when/where was it done?	
Records available from that visit?	☐ No ☐ Yes	If 'yes' are records attached?	☐ No ☐ Yes

Other pertinent information:	