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TREATMENT PROGRAM FOR CHILDREN WITH PROBLEMATIC SEXUAL BEHAVIORS REFERRAL FORM

Date of referral: _____
Child's last name: _____ Child's first name: _____
Child's date of birth: _____ Age: _____ Gender: Male Female Other
Child's ethnicity: _____

REFERRAL SOURCE INFORMATION

Contact person: _____ Agency: _____
Office phone: _____ Cell phone: _____ Email: _____
Report made to DHS/ICW? Yes No DHS/ICW involvement: No Yes-Past Yes-Current
If yes, caseworker name: _____ Primary County: _____
Caseworker phone: _____ Cell phone: _____ Fax: _____
Caseworker email: _____
Estimated investigation closure date: _____
Is child in therapeutic foster care? No Yes – Agency: _____
Is law enforcement/JB/OJA involved? No Yes – Contact person: _____
Contact phone: _____ Cell phone: _____ Fax: _____
If there is an open investigation, please use the space below to describe the next steps of the investigation:

Caregiver notified of referral: Yes No – Please notify caregiver immediately.

Is biological mother's parental rights terminated? Yes No Do not know N/A
Is biological father's parental rights terminated? Yes No Do not know N/A
Is there a plan for reunification with parents? Yes No Do not know N/A
Is there a permanency plan for the child? Yes No Do not know N/A

If necessary, then please use the space below to elaborate on the permanency plan:

CAREGIVER INFORMATION

Primary caregiver's name(s): _____

Primary caregiver's name(s): _____

Date(s) of birth: _____ Ethnicity: _____

Relationship to child: _____

Address: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Alternate phone: _____ Good time to call: AM PM EVE Other: _____

Legal Guardian: Caregiver DHS Other: _____

BIOLOGICAL PARENT INFORMATION – If different from caregiver above

Parent's name: _____

Date of birth: _____ Ethnicity: _____

Relationship to child: _____

Address: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Alternate phone: _____ Good time to call: AM PM EVE Other: _____

BIOLOGICAL PARENT INFORMATION – If different from caregiver above

Parent's name: _____

Date of birth: _____ Ethnicity: _____

Relationship to child: _____

Address: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Alternate phone: _____ Good time to call: AM PM EVE Other: _____

OTHER PROFESSIONALS

Therapist: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Systems of Care: _____ Phone: _____

Other: _____ Phone: _____

REASON FOR REFERRAL- Referral Source Report

Is Referral Source a caregiver? No Yes

What are the specific sexual behaviors of concern that the child has demonstrated?

When did the last incident occur? _____ How many incidents are known? _____

With whom did the child have the problematic sexual behaviors?

Name	Age	Relationship to referred child	Need Services related to the incident?*

Has the child ever initiated sexual contact? Yes No Was coercion used? Yes No

Does the child have additional behavioral concerns?

*If other children noted are relatives and need services so that family therapy, reunification, and other similar factors need to be considered, then please provide details:

CHILD VICTIMIZATION HISTORY

Has child had a victimization experience? Yes / Suspected* – Complete below (check all that apply) No

- Physical abuse Sexual abuse Neglect Psychological / Emotional
 Bullying Hate Crime School violence Kidnapping
 Community violence Accident War/terrorism

Witnessing intimate partner violence (IPV) / Domestic violence (DV)

Other: _____

Details:

Has child completed a forensic interview? Yes No, but will complete No, not needed Unsure

Date forensic interview is scheduled or completed: _____

Where was or will the forensic interview completed? _____

Concerns about child (check all that apply): No identifiable problems; child appears to be functioning well

- Not minding Moody / Sad Hyperactivity Sleep problems / Nightmares
 Self-harm Low self-esteem Anger / Aggression Bothersome memories
 Somatic complaints Anxiety / Fear Poor school performance Overwhelming grief
 Wetting / Soiling self Sexualized behavior

Problematic interactions with friends Problematic interactions with caregivers

Risk taking behaviors: _____

Other – Explain: _____

Details:

Strengths of the Child:

**PRINT and EMAIL completed forms to desiree@myblueprintcounseling.com
ATTN: PSB Program**

The Program Coordinator will contact the parent/legal guardian for additional information and, if appropriate, schedule an intake assessment for the child.

→ A custodial caregiver must attend the intake assessment with the child. ←

Questions? Contact the PSB Program Coordinator, Desiree Lambert (Blueprint Counseling) 910.690.2862