Philadelphia Children's Alliance

INTAKE REFERRAL

Fax to (215) 387-9513 or
E-mail Intake@philachildrensalliance.org

Name (of person making referral): _____

Referral for: ☐ Forensic Interview ☐ Victim Services only

Investigative Team (please fill in as much as known and check off which agency you are from):

☐ **DHS/DPW** Name _____
Phone _____

☐ **Police** Name _____
Phone _____

☐ **District Attorney** (if applicable) Name _____
Phone _____

☐ **DHS On-Going Worker** Name _____
Phone _____

Child Information:

Name _____ Date of Birth _____ Age _____

Social Security Number _____ Race _____ Gender _____

Primary Language _____ Child's Current Location _____

If more than one child, please list additional names and dates of birth:

_____

_____

Caretaker Information:

Name _____ Relationship _____

Address _____ Phone Number _____

Cell Number _____

Alleged Perpetrator(s) (If more than one AP, please list information in Additional section):

Name _____ Relationship _____

Date of Birth _____ Address _____

Phone Number _____

Additional information _____
_____
_____

Allegations:

Date of DHS report _____ Date of Police report _____

DHS Number _____ DC# _____ S#_____

Narrative to Hotline or CY-47:
_____
_____
_____
_____
_____

Please attach actual Hotline report/ CY-47 if available.

Previous Investigations of Abuse (including prior PCA interviews):
_____
_____

Other Relevant Information (special needs, mental health issues, linguistic/developmental/physical)
_____
_____

Schedule Restrictions for family members/workers/ investigators (if applicable):
_____

Signature: _____ Date: _____

After we receive this intake form, an Intake Coordinator will contact you as soon as possible to set up an appointment. Thank you!

Children's Hospital of Philadelphia℠

MR-109
Rev. 3/21

LAST NAME _____ FIRST NAME _____

MR# _____ DOB _____

PLACE PATIENT LABEL HERE *OR* COMPLETE ABOVE

DO NOT HANDWRITE PATIENT INFORMATION HERE

AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

This authorizes Children's Hospital of Philadelphia and its affiliates to release/obtain information as described below. For a listing of related entities and medical practices, see Children's Hospital of Philadelphia *Notice of Privacy Practices*.

1. **Patient Name (First, Middle, Last):** _____
   Address of Patient: _____
   City, State, Zip: _____
   Telephone Number: _____ **Date of Birth:** _____

2. **What is the name of the person or facility that will be releasing your information?** Check the appropriate box below and provide the name, address and telephone number of the person/facility releasing the information.
   ☐ **Children's Hospital of Philadelphia** or ☐ **Other**
   Name of Person / Facility: _____
   Address: _____
   City, State, Zip: _____
   Telephone Number: _____ Fax Number: _____

3. **What information will be released?** Date of appointment or hospital stay beginning _____ through to _____
   ☐ **Emergency Department** ☐ **Home Care** ☐ **Outpatient** _____
   ☐ **Inpatient** ☐ **Immunization** *(please specify name of department/office)*
   ☐ **Other Information** *(please specify)* _____
   If there is any part of the record you do not wish released, please indicate here: _____
   If your records contain any information about substance (drug or alcohol) abuse, HIV, or mental health, may this information be released? If yes, please initial next to each type of information to be released:
   Drug and/or alcohol treatment or testing _____ **HIV** _____ **Mental Health** _____

4. **Medical Record delivery format:** If no selection is made, default will be Paper.
   ☐ **Paper** ☐ **CD** ☐ **MyCHOP** *(active account needed)* ☐ **Fax** ☐ **Other** _____

5. **What is the name of the person or facility who is to receive your information?** Check the appropriate box below and provide the name, address and telephone number of the person/facility releasing the information.
   ☐ **Children's Hospital of Philadelphia** or ☐ **Other**
   Name of Person / Facility: _____
   Address: _____
   City, State, Zip: _____
   Telephone Number: _____ Fax Number: _____

6. **Please explain why the person or facility above needs this information:**
   _____

7. **Expiration.** Your permission will expire 90 days after you sign this form unless you indicate otherwise. If you would like to extend your permission for longer than 90 days, please tell us when your permission expires. The date cannot be more than a year from now: _____.

8. **Understanding this Authorization**
   - This allows the release or obtaining of information that exists in the patient's medical record when the form is signed, as well as information created after the form is signed until it expires.
   - I may withdraw my permission at any time by providing written notice to the above-named provider releasing the information. For information being released by Children's Hospital of Philadelphia, see its *Notice of Privacy Practices* for instructions on how to withdraw (revoke) an authorization. If I withdraw my permission, any information that was already released cannot be retrieved.
   - Information released by Children's Hospital of Philadelphia may be released again by the person or organization that receives it and is no longer protected under federal privacy laws. Children's Hospital of Philadelphia will protect information it obtains as required by federal privacy laws.
   - I understand my permission is voluntary and I/my child will receive treatment whether or not I sign this form.

9. **Signature.** By signing, I understand that I am authorizing Children's Hospital of Philadelphia to release/obtain information as described above.

_____ Signature _____ Printed Name _____ / _____ Date Time

Relationship to patient: ☐ Patient ☐ Parent ☐ Legal Guardian ☐ Other: _____

Information Released by: _____ Date: _____

WHITE – MEDICAL RECORDS **YELLOW – PATIENT/PARENT/LEGAL GUARDIAN**

Our Commitment to Diverse Populations

The Children's Hospital of Philadelphia complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Children's Hospital of Philadelphia does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Children's Hospital of Philadelphia:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact 1-800-879-2467.

If you believe that Children's Hospital of Philadelphia has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Family Relations Office, 3401 Civic Center Blvd, Philadelphia, PA 19104, Phone: 267-426-6983, Fax: 267-426-7412, Email: familyrelations@email.chop.edu
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Family Relations is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

October 2016

CHOP is Committed to Language Accessibility

If you speak another language, assistance services, free of charge, are available to you.

Español-Spanish ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-879-2467.

繁體中文–Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-879-2467。

العربية -Arabic ملحوظة: إذا كنت تتحدث اللغة العربية فإن خدمات المساعدة اللغوية تتوفر لك بالمجان- اتصل بالرقم 1-800-879-2467.

Tiếng Việt-Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-879-2467.

Français-French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-879-2467.

Português-Portuguese ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-879-2467.

नेपाली-Nepali ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-879-2467 ।

ខ្មែរ-Cambodian ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 1-800-879-2467។

বাংলা-Bengali লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-879-2467।

Русский-Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-879-2467.

한국어-Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-879-2467 번으로 전화해 주십시오.

Bahasa Indonesia-Indonesian PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-800-879-2467.

اُردُو -Urdu خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-879-2467 .

Türkçe-Turkish DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-800-879-2467 irtibat numaralarını arayın.

Polski-Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-879-2467.

Italiano-Italian ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-879-2467.

हिंदी-Hindi ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-879-2467 पर कॉल करें।

ગુજરાતી-Gujarati સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-879-2467.

Tagalog-Tagalog-Filipino PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-879-2467.

日本語 -Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-879-2467 まで、お電話にてご連絡ください。

Deutsch-German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-879-2467.

Deitsch-Pennsylvania Dutch Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-800-879-2467.