Georgia Cares Referral Form
Medical
Fax to: 404-371-1030 or
Email to: referrals@gacares.org

Client's Information

Youth Name: Social Security Number:

Date of Birth: Gender:

Is client pregnant?☐ Yes ☐ No Is client actively parenting?☐ Yes ☐ No

Ethnicity: Language Spoken: Does youth have a disability?

Who has custody of youth? ☐ Parents ☐ Father ☐ Mother ☐ DFCS ☐ DJJ ☐ Other:

If in the custody of DFCS or DJJ, when did custody begin?

Client's Address

Legal address: County:

Is this youth's current address? ☐ Yes ☐ No Is this a safe location? ☐ Yes ☐ No

Current address (if different): County:

Is this a safe location? ☐ Yes ☐ No

Contact:

Name of legal guardian: Phone number:

If youth does not reside with legal guardian, provide the phone number for current placement:

Medicaid /CMO ID: Insurance:

Please check all that applies:

☐ DJJ Committed ☐Criminal Trespassing ☐Custody of LawEnforcement (Detained by Law Enforcement) ☐DFCS Involvement (Foster Care) ☐DFCS Involvement (Home) ☐Firearm/Weapon Use ☐Frequent Runner (Running 3 or more times in the past 6 months) ☐Gang Involvement ☐ Giving False Name ☐Homeless ☐Loitering for Solicitation ☐On Probation (DJJ or Court) ☐ Police Report ☐Runaway/Unruly Petition ☐Sexual Abuse ☐Sexual Exploitation ☐Shoplifting ☐Substance Abuse ☐Truancy/Suspension ☐Violation of Probation

Medical Staff Referral Information

Name of Hospital Making Referral:

Name of Referral Source:

Job Title:

County:

Phone Number:

Email Address:

Additional Information

Please provide the name, relationship and contact information for the individual who accompanied the child to the hospital.

Has the legal guardian been informed of this referral?☐ Yes ☐ No

Describe the stated reason for admission to the hospital:

When is the discharge date from the hospital?

Describe the medical status at the time of discharge:

Has the initial forensic medical exam been conducted? ☐ Yes ☐ No

Has a follow up medical exam been scheduled? ☐ Yes ☐ No

Has a forensic interview been scheduled? ☐ Yes ☐ No

Was a DFCS referral made? ☐ Yes ☐ No

Describe the reason for referral to Georgia Cares:

Please attach the following documents:

☐Release of Information (Required)

☐Additional necessary documents

Georgia Cares use only		
Date Received:	*Court or Community:*	*Log number:*