Intake Contact:

SBCLexington@dickersoncac.org

Safe Babies Court Lexington
Client Referral Form

Date of Referral: _____

Parent's Name:_____ Relationship to Child(ren): _____

Phone Number(s) (Home): _____(Cell): _____

Number of Child(ren):_____ Name(s) of Child(ren)/Age: _____

_____

Current Placement of Child(ren): _____

Placement Name/Contact Information:

Allegations:

☐ Sexual Abuse ☐ Physical Abuse ☐ Neglect ☐ Other: _____

Special Circumstances/Additional Information (Criminal Charges, No Contact Orders, etc.):

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Agencies Involved and Contact Information:

_____

Person/Agency Making Referral:_____

LE Contact:_____ Agency:_____

Email:_____ Phone:_____

DSS Contact:_____Email:_____Phone:_____

DSS Supervisor Contact:_____ Phone:_____

Date of next hearing:_____