



**Legacy Children's Center**

Salmon Creek  
2121 NE 139th Street, Building A, Suite #200  
Vancouver, Washington 98686-2742

**Phone: (360) 487-1793**

**Fax: (360) 487-1779**

Salmon Creek Tax ID: 33-1065485

Patient Name:
MR #: <i>Place Sticker Here</i>
DOB:

**CHILD ABUSE ASSESSMENT TEAM (CAAT) REFERRAL FORM**

***Referring party is required to make a report to 911 and CPS (888-713-6115). Prior to faxing this referral for medical evaluation, confirm by signature that reporting was done:***

***Signature:*** \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  Female  Male

Name of parent/guardian to be contacted to set up assessment: \_\_\_\_\_

Who is 'legal guardian'? \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Interpreter needed:  No  Yes If yes, what language: \_\_\_\_\_

Other pertinent notes, if any:

If you have questions, please contact CAAT staff at (360)487-1747.

Requestor: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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To be completed office staff

Date intake completed and forwarded to scheduler:

Assessment	Due (Month/Year)	Provider	Appointment Date/Time
<input checked="" type="checkbox"/> CAAT Assessment	Next Available	K. Copeland	

Medical ICD9 Code(s): \_\_\_\_\_ V71.5 \_\_\_\_\_