

# CARE Network Participation Form

## **PATIENT INFORMATION\***

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

\*To be eligible for a CARE Network assessment, children must be birth through five years of age if suspected as being physically abused or neglected or birth through twelve years of age for children suspected of being sexually abused.

## **MEDICAL ASSESSMENT FOR (SELECT ALL THAT APPLY):**

Sexual Abuse  Physical Abuse  Neglect

## **PARENT/GUARDIAN/LEGAL CUSTODIAN**

I understand that this is a CARE Network evaluation by a licensed professional who is specially trained to do evaluations when there is a concern about physical abuse or neglect. The CARE Network evaluation may benefit my child through a medical evaluation, and behavioral health and developmental screenings, that may result in my child receiving referrals for needed services. I understand that this may include additional tests or assessments. . The CARE Network provider will be available to share the results of the evaluation with me and to answer questions I may have. The results will be submitted to the Kempe Center, which serves as the Resource Center for the CARE Network, for the purposes of training, quality assurance and evaluation. Providers in the CARE Network may also share information for the purposes of referral and consultation.

I further understand that concerns or known incidents of suspected abuse or neglect will need to be referred to law enforcement or social services.

NAME: \_\_\_\_\_  Parent  Guardian  Legal Custodian

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

## **REQUESTING AGENCY**

AGENCY: \_\_\_\_\_

AGENCY REPRESENTATIVE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

CONTACT INFORMATION (email or phone if available): \_\_\_\_\_