Rock Island County Children's Advocacy Center
Problematic Sexual Behavior (PSB)

REFERRAL FORM

Name: _____ DOB: _____ Age: _____

Gender: ☐ Male ☐ Female

Race: ☐ Black ☐ White ☐ Asian ☐ Hispanic/Latino ☐ Pacific Islander

Address: _____
City State Zip

Parent/Guardian: _____ Relationship: _____

Phone: _____ Text: ☐ Yes ☐ No Leave Msg: ☐ Yes ☐ No

Reason(s) for PSB Referral: (*brief description of behavior)*

_____

_____

_____

_____

When did the last incident occur? _____
How many incidents are known? _____

Is there DCFS Involvement: ☐ Yes ☐ No *If yes, who:* _____

Is there Law Enforcement Involvement: ☐ Yes ☐ No *If yes, who:* _____

Was the parent/guardian notified about referral made: ☐ Yes ☐ No *If no, please notify the parent/guardian/caregiver about referral being made.*

Are there additional behavioral concerns? ☐ Yes ☐ No

_____

_____

Referral Source:

Name: _____ Agency: _____

Phone: _____ Email: _____

Please send referrals to cac@riccac.org