

# Children's Safe Center Referral Instructions

Instructions for using the Children's Safe Center Referral app

Children's Safe Center Referral [Home](#) [Complete Pending](#)

## Children's Safe Center Referral Form

\* - Required Fields

### Preferred location for exam

Preferred location for exam \*

Fields with the red asterisk are required in order to submit a referral.

## Referral Source

Name \*

Your information will be entered here. This will be the contact information the CSC will use.

Agency \*

Address

Address2

City

State

Zip

County \*

Daytime Phone \*

Alternate Phone

Fax Number

Email \*

## Patient Information

First Name \*

Last Name \*

Date of Birth \*



Sex \*

Race & Ethnicity \*

Address \*

Address2

City \*

State \*

Zip \*

Cell Phone \*

Alternate Number

Legal Guardian \*

When entering the patient information, please keep a copy of the **Last Name and DOB** for reference if the record needs to be looked up for any future edits.

Legal Guardian \*

After completion of the first page of the form,  
check the box for verification.

I'm not a robot



reCAPTCHA  
Privacy - Terms

Click the Start Referral button to submit the  
information entered above. The next step will take  
you to the section where you will enter more  
information about the patient.

Start Referral

## Step 2 for submitting the patient for referral

This is what you will see for the next steps in completing the referral. Complete as much of the information shown in the following slides as possible.

If you do not have all of the information to complete the referral, there is an option to save and instructions on how to do so will be shown in a later slide.

Children's Safe Center Referral - Home - Complete Pending

### Record Locator

Record locator number for this referral

Referral is currently in draft status

### Update Referral Information

Preferred location for exam \*

Grenada

Special Classification

Deaf/Hard of Hearing       Victims with Limited English Proficiency       Victims with Disabilities – Cognitive/Physical/Mental

Child is also suspected youthful offender \*      Physical signs or symptoms present now? \*

First Name

Edit

If the exact date/time is known for the last incident and/or contact, enter that here.

Last Incident Date/Time

mm/dd/yyyy --:-- --



or

Approximate Time Since Last Incident

Last Contact Date/Time

mm/dd/yyyy --:-- --



or

Approximate Time Since L

Hours ago  
Days ago  
Weeks ago  
Years ago

Seen by CAC? \*

If 'Yes' is selected here, an additional text box will appear in order to enter more information.

If the exact date/time is not known for the last incident and/or contact, enter the time frame here.

Check as many boxes as needed for the referral.

Physical Abuse \*

- Bruise(s)
- Head trauma
- Medical child abuse
- Unspecified physical abuse

- Scar(s)
- Skeletal fracture(s)
- Poisoning
- N/A
- Burn(s)
- Abdominal trauma
- Death

Sexual Abuse \*

- Pornography
- Oral-genital or genital-oral
- Pregnancy
- N/A

- Sexualized behavior
- Penile- oral/vaginal/anal
- Unspecified sexual abuse
- Genital touching
- Sex transmitted infection(s)
- Human Trafficking: Sex

Neglect \*

- Medical
- Foster Care Intake

- Nutritional- Failure to thrive
- Collateral child (include all children in environment where another child is suspected of abuse or neglect)
- Unspecified neglect
- N/A

Neglect \*

Medical

Nutritional- Failure to thrive

Unspecified neglect

Foster Care Intake

Collateral child (include all children in environment where another child is suspected of

N/A

If you have filled out all of the required information and are ready to submit the referral, click the Save button.

Save

Close

If you do not have all of the information needed and would need to come back to this submission to complete it, click on the Close button and follow the instructions on the next page.



When you click Save or Close, you will see the following page. The Record Locator ID is created for this referral. If you would need to come back and enter more information **before submitting the referral**, you will need this ID number, the patient's name and DOB.

Note the red box that this is not a completed referral. It is not completed until all required fields are entered and the referral submitted from this page. See next pages for instructions on submitting.

Children's Safe Center Referral Home Complete Pending

## Record Locator: FGV749

Record locator number for this referral is 'FGV749', please keep this for your records.

Referral is currently in draft status, please complete all sections below and click 'Submit Referral'

Patient Information

Edit

Referral Source

If any of this information needs to be updated before submitting, you can do so here.

### Patient Information

[Edit](#)

<b>First Name</b>	Patient
<b>Last Name</b>	Name
<b>Date of Birth</b>	2/2/2020
<b>Sex</b>	Male
<b>Race &amp; Ethnicity</b>	Some Other Race
<b>Address</b>	234 Side Street
<b>Address2</b>	
<b>City</b>	Tupelo
<b>State</b>	MS
<b>Zip</b>	38801
<b>Cell Phone</b>	(662) 555-1357
<b>Alternate Number</b>	
<b>Legal Guardian</b>	Legal Guardian

### Referral Source

[Edit](#)

<b>Name</b>	Referral Name
<b>Agency</b>	Agency Name
<b>Address</b>	
<b>Address2</b>	
<b>City</b>	
<b>State</b>	
<b>Zip</b>	
<b>Daytime Phone</b>	(662) 555-7890
<b>Alternate Phone</b>	
<b>Email</b>	test@agency.com

## Referral Info

**Preferred location for exam** Grenada

**Child is also suspected youthful offender**

**Special Classification**

**Physical signs or symptoms present now?**

**Please describe symptoms**

**Last Incident Date/Time**

**Approximate Time Since Last Incident**

**Last Contact Date/Time**

**Approximate Time Since Last Contact**

**Seen by CAC?**

**If Yes, when and where was patient seen by CAC.**

**Physical Abuse**

**Sexual Abuse**

**Neglect**

Click the Edit button to enter/update any information here.

Edit

**Suspected Perpetrator(s)**  
No Perpetrator(s) Added [Add Perpetrator](#)

**Other Agencies Involved**  
No Other Agencies Added [Add Other Agency](#)

**Supporting File(s)**  
No Supporting Files Uploaded [Add Attachment\(s\)](#)

[Submit Referral](#)

Click the Add button to enter as many instances of each as needed.

Click to upload any files that would need to be included in the referral.

If you have completed all required fields and are ready to submit to the CSC for referral, click here.

If you are not able to submit and need to save this for completion at a later date, you will need the ID number provided above (and in an email sent to the email address provided), the patient's last name and DOB. Following are the instructions on how to search for a record in order to complete later.

# Searching for a saved record

[Children's Safe Center Referral](#) [Home](#) [Complete Pending](#)

## Record Locator

\* - Required Fields

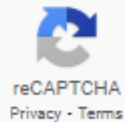
Record Locator \*

Patient Last Name \*

Date of Birth \*

I'm not a robot



[Find Record](#)

To return to a saved draft, click on the Complete Pending link to get to this search page.

Enter the record ID, last name, DOB to find the saved submission.

You will come back to this page, where you can complete the information for the referral.

Children's Safe Center Referral - Home - Complete Pending

## Record Locator

Record locator number for this referral

Referral is currently in draft status

### Patient Information

First Name

### Update Referral Information

Preferred location for exam \*

Grenada

Special Classification

Deaf/Hard of Hearing     Victims with Limited English Proficiency     Victims with Disabilities - Cognitive/Physical/Mental

Child is also suspected youthful offender \*    Physical signs or symptoms present now? \*

Edit

Neglect \*

- Medical     Nutritional- Failure to thrive     Unspecified neglect
- Foster Care Intake     Collateral child (include all children in environment where another child is suspected of

If you have filled out all of the required information and are ready to submit the referral, click the Save button.

Save

Close

## Suspected Perpetrator(s)

No Perpetrator(s) Added

Add Perpetrator

## Other Agencies Involved

No Other Agencies Added

Add Other Agency

## Supporting File(s)

No Supporting Files Uploaded

Add Attachment(s)

When you have filled out all of the required information and are ready to submit the referral, click the button.

Submit Referral

You will get this pop-up to confirm if you are ready to submit the referral. Clicking OK will submit the referral to the CSC.

Are you sure you want to submit this referral?

OK

Cancel