

**POST FORENSIC INTERVIEW FORM**

Date of Interview: \_\_\_\_\_

County: \_\_\_\_\_

<b>CLIENT Name:</b> _____	<b>DOB:</b> _____
<b>Mother's Name:</b> _____	<b>Phone #:</b> _____
<b>Father's Name:</b> _____	<b>Phone #:</b> _____
<b>ALLEGED OFFENDER Name:</b> _____ <b>Age:</b> _____ <b>Relation to Victim:</b> _____	
<b>Allegation:</b> _____	

**DISCLOSURE** Yes: \_\_\_\_\_ No: \_\_\_\_\_ Other: \_\_\_\_\_ Please explain: \_\_\_\_\_

**MEDICAL EXAM Referral Made?** YES \_\_\_\_\_ NO \_\_\_\_\_

If not, why? \_\_\_\_\_ Disclosure was not made

\_\_\_\_\_ A SANE exam has already been completed for **this allegation**

\_\_\_\_\_ Other (please explain) \_\_\_\_\_

**MENTAL HEALTH? Would you like to make a referral to Mental Health Specialist?**

**YES Which services?**

\_\_\_\_\_ Referral for victim assessment or counseling

\_\_\_\_\_ Referral for family assessment, education, or counseling

Briefly describe mental health concerns/issues: \_\_\_\_\_

**NO Why not?**

\_\_\_\_\_ A **mental health provider** is already involved:

**NAME OF PROVIDER:** \_\_\_\_\_ **PHONE #** \_\_\_\_\_

Are there any safety concerns at this time? (Consider suicidal, risk of re-victimization) \_\_\_\_\_

Action taken: \_\_\_\_\_

**MDT MEMBERS PRESENT**      **CASE #** \_\_\_\_\_

PRINTED NAME	SIGNATURE	E-MAIL ADDRESS / PHONE #