

**ANOKA COUNTY HUMAN SERVICES DIVISION  
REFERRAL OF SUSPECTED CHILD ABUSE/NEGLECT**

Please complete as much of the requested information as possible.

**FAMILY INFORMATION:**

Date of Report: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of birth or age: \_\_\_\_\_

Name of School (or daycare): \_\_\_\_\_ Grade: \_\_\_\_\_

Parent(s)/Guardian: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Other children in the home (list names and DOB, if known): \_\_\_\_\_

**PERSONS NOTIFIED OF THIS REPORT:**

- |  |   |
|--|---|
| <input type="checkbox"/> Child               | <input type="checkbox"/> Principal                      |
| <input type="checkbox"/> Parent              | <input type="checkbox"/> Nurse/health aide              |
| <input type="checkbox"/> Alleged Perpetrator | <input type="checkbox"/> Counselor/School Social Worker |
| <input type="checkbox"/> Police              | <input type="checkbox"/> Other: _____                   |

Name of alleged perpetrator: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**REASON FOR REFERRAL:** *(Please include conditions, dates, descriptions of injury, statements of child, etc.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reporter's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Agency/School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

You may send a copy to: Anoka County Human Services Division  
Child Protection Intake  
2100 3<sup>rd</sup> Avenue, Suite 500  
Anoka, MN 55303-5049

Or fax to: (763) 324-1039 To make oral reports please call (763) 324-1440.  
You will receive an outcome report after the investigation is complete.