New Westminster Office
Phone: 604-520-0009
Fax: 604-520-6100

Cameray Child and Family Services

BRIEF COUNSELLING REFERRAL FORM

Burnaby Office
Phone: 604-436-9449
Fax: 604-436-1990

DATE: ______________________________
MONTH DAY YEAR

CONTACT INFO

Child's Name:______________________ Sex:____ Age:____ DOB:____________ School:____________
MONTH DAY YEAR
Siblings Name:_________________ Sex:_____ Age:_____/Name:________________ Sex:____ Age:____
Parent(s) Name:______________________________________ Home Phone #: (_____) _______________
Work # (mom):_____________ (dad):_____________ Cell # (mom):____________ (dad):______________
Address:____ Postal Code:_______________
Guardian(s) (*if applicable*):_________________________ Phone: (H)______________ (W)____________
Address:______________________________________ Postal Code:______________ (C) _____________

CLIENT INFO

Custody Info: ❑ 2P ❑ SP/mom ❑ SP/dad ❑ co-parents ❑ in care ❑ with relative
❑ with friend ❑ independent living
Number in family: ______ Is family on Income Assistance? ❑ *yes* ❑ *no* Aboriginal/Métis? ❑ *yes* ❑ *no*
Language spoken at home: _____________________ Family informed of referral and contents? ❑ *yes* ❑ *no*
Previous Cameray involvement? ❑ *yes* ❑ *no* Cameray Program(s) and date(s): ______________________

Referring Individual:____ Phone:__________________
Position and Office Code: ___________________ Does social worker want contact with counsellor ❑ *yes* ❑ *no*

I) If **Sexual Abuse disclosure**, please state what was reported, to whom, and the approximate date: ____________
____
____

a) Was child interviewed by MCFD? ❑ *yes* ❑ *no* Please include contact names: ________________________

b) Was child interviewed by police? ❑ *yes* ❑ *no* Please include contact names: ________________________

c) **Identify present crisis**: ____
____
____

II) If **Family/Trauma crisis**, please state the current crisis: ____________________________________
____
____

III) **Identify events** that led up to the crisis: ____
____
____

IV) **Other**: (*Please provide details.*) Medication: ❑ *yes* _______________________ ❑ *no*
Suicidality: ____
Mental Health involvement: ____
Substance abuse: ____
Other referrals made: ____
MCFD file status: ❑ Open service ❑ Close after referral ❑ Transfer to other social worker_____________

Program Assigned: __________________________ ❑ *Priority* *Client offered*: ❑ *CVSS* ❑ *PSP* *Approved by:* _________
Counsellor Assigned: ___________________________________ *Date File Opened:* ____________________________
❑ *On computer* *Referral No*: _____________________ *Termination Date*: ___________________________ ❑ *NCM*