

Cameray Child and Family Services
Child & Youth Victim Support Service – Referral Form

DATE OF REFERRAL: _____

Client: _____ Sex: _____ Age: _____ DOB: _____
MONTH DAY YEAR

Parent/Guardian: _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ Work Phone: (_____) _____

Address: _____ City: _____ Postal Code: _____

Client Type: Primary Victim Secondary Victim Witness

Offence Type: Child Sexual Abuse Child Physical Abuse Criminal Harassment

Spousal Assault Other _____

Summary of Client Issues/Concerns: _____

Referring Individual: _____ Phone: (_____) _____

Referral Source (select one): Verbal consent to collect personal information? yes no

Funded VAP – *Aboriginal* Funded VAP – *Police* Funded VAP – *Community*

Justice – *Crown* Justice – *Police* Justice – *Other*

Community Agency Hospital/Medical Ministry of Health MCFD

Private Practitioner Self Unknown Other _____

MCFD Involved? yes no Social Worker: _____ Phone: (_____) _____

Police Officer: _____ Police File #: _____

Police Phone #: (_____) _____ Date Reported: _____

Crown Counsel: _____ Crown File #: _____

Crown Phone #: (_____) _____ RTCC Sent to Crown? yes no

Offender: _____ adult youth

Charges: _____

In custody? yes no No Contact Conditions? yes no

Trial: Provincial Supreme Jury: yes no

To make a referral, phone 604-520-0009 or fax form to 604-520-6100

OFFICE USE ONLY	File #: _____	<input type="checkbox"/> Entered on computer	Initials: _____
	Date Opened: _____	Support Worker: _____	