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: (______)_________________

Safe to Call? ❑ yes ❑ no Safe to Leave Message? ❑ yes ❑ no

Address: _____________________________ City: ______________ Postal Code: ______________

Client Type: ❑ Primary Victim ❑ Secondary Victim ❑ Witness

Offence Type: ❑ Child Sexual Abuse ❑ Child Physical Abuse ❑ Criminal Harassment

❑ Spousal Assault ❑ Other _______________________________________

Brief Summary of Incident: ____

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Police Officer: _____________________________ Police File #: ___________________________

Police Phone #: (______)____________________ Date Reported: _________________________

Crown Counsel: ____________________________ Crown File #: ___________________________

Crown Phone #: (______)____________________ RTCC Sent to Crown? ❑ yes ❑ no

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: (____)_________

Offender: ____ ❑ adult ❑ youth

Charges: ____

In Custody? ❑ yes ❑ no No Contact Conditions? ❑ yes ❑ no

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

OFFICE USE ONLY	File #: ____________________________________	❑ Entered on computer	Initials: ___________
	Date Opened: ______________________________	Support Worker: ______________________________	