Cameray Child and Family Services

Child & Youth Victim Support Service – Referral Form

DATE OF REFERRAL: ______________________
MONTH DAY YEAR

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 #: ______________________ ❑ Entered on computer Initials: ________

Date Opened: ______________________ Support Worker: ______________________