

Cameray Child and Family Services COUNSELLING REFERRAL FORM

DATE: _____
Month Day Year

CONTACT INFO	Child's Name: _____ Sex: _____ Age: _____ DOB: _____ School: _____ <small>MONTH DAY YEAR</small>
	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: <input type="checkbox"/> 2P <input type="checkbox"/> SP/mom <input type="checkbox"/> SP/dad <input type="checkbox"/> co-parents <input type="checkbox"/> in care <input type="checkbox"/> with relative <input type="checkbox"/> with friend <input type="checkbox"/> independent living
	Number in family: _____ Is family on Income Assistance? <input type="checkbox"/> yes <input type="checkbox"/> no Aboriginal/Métis? <input type="checkbox"/> yes <input type="checkbox"/> no
	Language spoken at home: _____ Family informed of referral and contents? <input type="checkbox"/> yes <input type="checkbox"/> no
	Previous Cameray involvement? <input type="checkbox"/> yes <input type="checkbox"/> no Cameray Program(s) and date(s): _____

Referring Individual: _____ Phone: _____
Position and Office Code: _____ Does social worker want contact with counsellor? <input type="checkbox"/> yes <input type="checkbox"/> no

- PROGRAM REFERRED TO:** Sexual Abuse Program (complete all 3 sections)
 Family Program (go to part II) Trauma Program (go to part II) High-Risk Youth Program (go to part II)
 Inappropriate Sexual Touching (SHIP) (children 12 and under) (go to part II)

I) If **Sexual Abuse Program**, 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: _____

II) **Presenting Problem:** _____

- III) **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: _____ <input type="checkbox"/> Priority	Client Offered: <input type="checkbox"/> CVSS	Approved by: _____
Counsellor Assigned: _____	Date File Opened: _____	
<input type="checkbox"/> On computer	Referral No: _____	Termination Date: _____ <input type="checkbox"/> NCM