

Cameray Child and Family Services
SEXUAL HEALTH INTERVENTION PROGRAM (SHIP)
REFERRAL FORM

Date: _____ Referral Completed By: _____
 MONTH DAY YEAR

Child's Name: _____ Sex: _____ Age: _____ DOB: _____ School: _____	
<small>MONTH DAY YEAR</small>	
Sibling's Name: _____ Age: _____ Sex: _____ /Name: _____ Age: _____ Sex: _____	
Parent(s): _____ Phone: (H) _____ (W) _____	
Address: _____ Postal Code: _____	
Guardian(s) (if applicable): _____ Phone: (H) _____ (W) _____	
Address: _____ Postal Code: _____	
Custody Info: <input type="checkbox"/> 2P <input type="checkbox"/> SP/mom <input type="checkbox"/> SP/dad <input type="checkbox"/> in care <input type="checkbox"/> with relative <input type="checkbox"/> with friend <input type="checkbox"/> independent living	
Has family been informed of referral and contents? <input type="checkbox"/> yes <input type="checkbox"/> no Is family on Income Assistance? <input type="checkbox"/> yes <input type="checkbox"/> no	
Has family had previous involvement at Cameray? <input type="checkbox"/> yes <input type="checkbox"/> no Program(s): _____ Date(s): _____	

Referring Individual: _____
Position and Office: _____ Phone: _____

MCFD Involvement: Social Worker: _____
Office Code: _____ Phone: _____ Does social worker want contact with counsellor? <input type="checkbox"/> yes <input type="checkbox"/> no

Presenting Problems: _____

Medical or Developmental Problems: _____

Others Involved: _____

Previous Treatment: _____

Other Information: _____

Nature of the sexual behaviour, frequency and duration: _____

With whom, relationship, age differential: _____

Accompanying aggression or coercion: _____

Child's response to discovery, the responses of significant others: _____

Is there a history of sexual victimization?: _____

Have child protective services been involved (MCFD or police)?: _____

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 _____

DECISION MAKING GRID *(please check):*

Other children/adults are unsafe with referred child.

Referred child is preoccupied with sexual activity (high frequency)

Normal development is interrupted

Child is stigmatized by sexual behaviour

Coercion is exercised in engaging other children

Aggression is exhibited.

Victim-centred treatment increases intrusive behaviours.

This Referral Form is designed to conduct initial screening by Cameray Co-ordinators. If the referral seems appropriate, an assessment and evaluation will be conducted by a SHIP Counsellor. For further information, please contact the office co-ordinator at:

Cameray Child & Family Services Phone: 604-436-9449 Fax: 604-436-1990

#203 – 5623 Imperial St. Burnaby, BC V5J 1G1

Program Assigned: _____ Priority Client offered: CVSS PSP Approved by: _____

Counsellor Assigned: _____ Date Filed Open: _____

On computer Referral No: _____ Termination Date: _____ NCM