

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