Cameray Child and Family Services

SEXUAL HEALTH INTERVENTION PROGRAM (SHIP)

REFERRAL FORM

Date: ____________________ (MONTH / DAY / YEAR) Referral Completed By: ____________________

Child's Name: ____________________ Sex: ____ Age: ____ DOB: ____________ (MONTH DAY YEAR) School: ____________
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: ❑ 2P ❑ SP/mom ❑ SP/dad ❑ in care ❑ with relative ❑ with friend ❑ independent living
Has family been informed of referral and contents? ❑ *yes* ❑ *no* Is family on Income Assistance? ❑ *yes* ❑ *no*
Has family had previous involvement at Cameray? ❑ *yes* ❑ *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? ❑ *yes* ❑ *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 by 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* *Approved by:* ______________

Counsellor Assigned: ______________ *Date File Opened:* ______________

❑ *On computer* *Referral No*: ______________ *Termination Date*: ______________ ❑ *NCM*