

*Cameray Child and Family Services*

**SHORT TERM (CRISIS) REFERRAL FORM**

New Westminster Office  
 Phone: 604-520-0009  
 Fax: 604-520-6100

Burnaby Office  
 Phone: 604-436-9449  
 Fax: 604-436-1990

**DATE:** \_\_\_\_\_  
MONTH DAY YEAR

<b>CONTACT INFO</b>	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) _____

<b>CLIENT INFO</b>	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
	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

I) If **Sexual Abuse disclosure**, 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: \_\_\_\_\_  
 c) **Identify present crisis:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

II) If **Family/Trauma crisis**, please state the current crisis: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

III) **Identify events** that led up to the crisis: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

IV) **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 <input type="checkbox"/> PSP	Approved by: _____
Counsellor Assigned: _____	Date File Opened: _____	
<input type="checkbox"/> On computer Referral No: _____	Termination Date: _____	<input type="checkbox"/> NCM