Cameray
Child & Family Services

CHILD VICTIM SUPPORT SERVICE REFERRAL FORM

DATE *MONTH* *DAY* *YEAR*

CLIENT:	Gender:	Age:	DOB: MONTH DAY YEAR
Parent/Guardian:		Home Phone:	
Cell Phone:		Work Phone:	
Email:			
Safe to Call? ☐ Yes ☐ No		Safe to Leave Message? ☐ Yes ☐ No	
Address:	City:	Postal Code:	
Client Type: ☐ Primary Victim	☐ Secondary Victim	☐ Witness	
Offence Type: ☐ Child Sexual Assault/Abuse	☐ Youth Sexual Assault/Abuse		
☐ Partner Physical Assault/Abuse	☐ Child/Youth Physical Assault/Abuse	☐ Other:	
Brief Summary of Incident:			

Police Officer:	Police File #:
Police Phone #:	Date Reported:
Location of Incident:	Incident Date:

Crown Counsel:	Crown File #:
Crown Phone #:	RTCC Sent to Crown? ☐ Yes ☐ No

Referring Individual:			Phone:
REFFERAL SOURCE ***(select one)*****:** Verbal consent to collect personal information? ☐ Yes ☐ No			
☐ Funded VAP – Aboriginal	☐ Funded VAP – Police	☐ Funded VAP - Community	
☐ Justice - Crown	☐ Justice – Police	☐ Justice - Other	
☐ Community Agency	☐ Hospital/Medical	☐ Ministry of Health	☐ MCFD
☐ Private Practitioner	☐ Self	☐ Unknown	☐ Other:

MCFD Involved? ☐ Yes ☐ No	Social Worker:	Phone:

Offender:	☐ Adult	☐ Youth
Charges:		
In Custody? ☐ Yes ☐ No	No Contact Conditions? ☐ Yes ☐ No	

Crime Victim Assistance Program Funding ☐ Yes	☐ No	☐ In Process

OFFICE USE ONLY

Referral taken by: _____ *File #:* _____ *Support Worker:* _____

☐ *On computer* *Date File Opened:* _____ *Closing Date:* _____ ☐ *NCM*

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