Cameray
Child & Family Services

COUNSELLING REFERRAL FORM

DATE *MONTH DAY YEAR*

CONTACT INFO

CHILD/YOUTH'S NAME:	Gender:	Age:	DOB: MONTH DAY YEAR
Child/Youth's Cell #:	School:		
Sibling Name:	Gender:	Age:	DOB:
Sibling Name:	Gender:	Age:	DOB:
Parent(s) Name:	Home Phone #:		
CELL # (mom):	(dad):		
WORK # (mom): EXT:	(dad): EXT:		
ADDRESS:	City: SELECT CITY	Postal Code:	
Guardian(s) *(if applicable)*:	Home Phone #:		
CELL #:	Work #: EXT:		
Address:	City: SELECT CITY	Postal Code:	
Email:			
PRIMARY CONTACT NAME:	Phone:		

CLIENT INFO

CUSTODY: ☐ 2 Parent ☐ SP/mom ☐ SP/dad ☐ Co-parents (*joint*) ☐ In Care ☐ With relative ☐ With friend ☐ Independent living

Family informed of referral and contents? ☐ *yes* ☐ *no*	DO NOT CONTACT PARENT(S): ☐
Language spoken at home:	Previous Cameray involvement?: ☐ *yes* ☐ *no*
Cameray Program(s) and date(s):	

NAME OF REFERRING INDIVIDUAL:		Phone:
Position:	Agency:	MCFD Office Code:
Open file with MCFD? ☐ *yes* ☐ *no*	Does social worker want contact with counsellor? ☐ *yes* ☐ *no*	
Email:		

PROGRAM: *BRIEF* (*up to 8 sessions; immediate*): ☐ Brief Family (*MCFD only*) ☐ Brief Sexual Abuse Counselling

LONG TERM (*up to 12 sessions; waitlist*): ☐ Family Program ☐ Sexual Abuse Intervention (SAIP) ☐ Trauma (*MCFD only*)

OTHER: ☐ High-Risk Youth *(Immediate; MCFD only)* ☐ Sexual Health Intervention (SHIP)

PRESENTING PROBLEM:

Mental Health involvement:

Other referrals made:

Crime Victim Assistance Program Funding: ☐ *yes* ☐ *no* ☐ *in process*

Has the child/youth been diagnosed or suspected of any of the following: ☐ FASD ☐ ADHD ☐ ASD
☐ Speech & Language Disorder ☐ Intellectual Disability ☐ Other Neurodevelopment Disorders:

If *Sexual Abuse Program*, please state what was reported, to whom, and the approximate date:

Was child interviewed by MCFD? ☐ *yes* ☐ *no*	Contact Names:
Was child interviewed by police? ☐ *yes* ☐ *no*	Contact Names:

OFFICE USE ONLY

Referral taken by: _____ ☐ *On computer*

Program Assigned: _____ ☐ *Priority* *Approved by:* _____

Counsellor Assigned: _____ *Date File Opened:* _____

Referral No: _____ *Closing Date:* _____ ☐ *NCM*

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