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*

5623 Imperial Street, Burnaby BC. V5J 1G1
Admin Office: #102 – Program Office: #203
Phone: 604-436-9449
Fax: 604-436-1990
Email: info@cameray.ca
www.cameray.ca