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

Cameray Child and Family Services

CHILD & YOUTH REFERRAL FORM

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

DATE: _____
MONTH DAY YEAR

Child's Name:_____ Sex:____ Age:____ DOB:_____ School:_____
MONTH DAY YEAR

Siblings Name:_____ Sex:____ Age:____/Name:_____ Sex:____ Age:____

Parent(s) Name:_____ Phone (Home): (_____) _____

(Work #) (mom):_____ (dad):_____ (Cell #) (mom):_____ (dad):_____

Address:_____ Postal Code: _____

Guardian(s) (*if applicable*):_____ Phone: (H)_____ (W)_____

Address:_____ Postal Code:_____ (C) _____

Custody Info: ❑ 2P ❑ SP/mom ❑ SP/dad ❑ in care ❑ with relative ❑ with friend ❑ independent living

Number in family: _____ Is family on Income Assistance? ❑ *yes* ❑ *no* Aboriginal/Métis? ❑ *yes* ❑ *no*

Family informed of referral and contents? ❑ *yes* ❑ *no* Previous Cameray involvement? ❑ *yes* ❑ *no*

Cameray Program(s) and date(s): _____

Referring Individual: Phone: _____ Fax: _____

Position: Mental Health Co-ordinator Signature: _____

Previous Mental Health Involvement: ❑ yes ❑ no Therapist: _____

Office: _____ Phone: (_____) _____

Comment: _____

MCFD Involvement: ❑ yes ❑ no Social Worker: _____

Office Code: _____ Phone: (_____) _____

Comment: _____

Medication: ❑ *yes* _____ ❑ *no*

Other Referrals Made: _____

Any Additional Information: _____

_____

_____

_____

OFFICE USE ONLY

Program Assigned to: CHILD & YOUTH *Counsellor Assigned to:* _____

❑ *On computer* ❑ *Priority* *Date picked up:* _____ *Approved by Coordinator:* _____

Referral Number: _____ *Termination Date:* _____ ❑ *NCM*