



SHORT TERM (CRISIS) REFERRAL FORM

DATE: _____
MONTH DAY YEAR

CONTACT INFO	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) _____

CLIENT INFO	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	Approved by: _____
Counsellor Assigned: _____	Date File Opened: _____	
<input type="checkbox"/> On computer	Referral No: _____	Termination Date: _____ <input type="checkbox"/> NCM