



**Cameray**  
Child & Family Services

# CHILD VICTIM SUPPORT SERVICE REFERRAL FORM

DATE                      MONTH                      DAY                      YEAR

<b>CLIENT:</b>		Gender:	Age:	DOB: _____ <small>MONTH                      DAY                      YEAR</small>
Parent/Guardian:			Home Phone:	
Cell Phone:			Work Phone:	
Email:				
Safe to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No			Safe to Leave Message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address:		City:	Postal Code:	
Client Type: <input type="checkbox"/> Primary Victim		<input type="checkbox"/> Secondary Victim		<input type="checkbox"/> Witness
Offence Type: <input type="checkbox"/> Child Sexual Assault/Abuse		<input type="checkbox"/> Youth Sexual Assault/Abuse		
<input type="checkbox"/> Partner Physical Assault/Abuse		<input type="checkbox"/> Child/Youth Physical Assault/Abuse		<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Referring Individual:</b>	Phone:		
<b>REFERRAL SOURCE (select one):</b> Verbal consent to collect personal information? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Funded VAP – Aboriginal	<input type="checkbox"/> Funded VAP – Police	<input type="checkbox"/> Funded VAP - Community	
<input type="checkbox"/> Justice - Crown	<input type="checkbox"/> Justice – Police	<input type="checkbox"/> Justice - Other	
<input type="checkbox"/> Community Agency	<input type="checkbox"/> Hospital/Medical	<input type="checkbox"/> Ministry of Health	<input type="checkbox"/> MCFD
<input type="checkbox"/> Private Practitioner	<input type="checkbox"/> Self	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other:

MCFD Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Worker:	Phone:
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Offender:	<input type="checkbox"/> Adult	<input type="checkbox"/> Youth
Charges:		
In Custody? <input type="checkbox"/> Yes <input type="checkbox"/> No	No Contact Conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Crime Victim Assistance Program Funding <input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> In Process
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<b>OFFICE USE ONLY</b>	File #: _____	<input type="checkbox"/> Entered on computer	Initials: _____
	Date Opened: _____	Support Worker: _____	