Cameray
Child & Family Services

COVID-19 YOUTH SUPPORT VIRTUAL COUNSELLING PROGRAM

DATE

CONTACT INFO

YOUTH'S NAME:	Gender:	Age:	DOB: MONTH DAY YEAR
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:	Postal Code:	
Email:	Would you like an email reminder for the **Intake** Appointment?: ☐ Yes ☐ No		
Guardian(s)*(if applicable)*:	Home Phone #:		
CELL #:	Work #: EXT:		
Address:	City:	Postal Code:	
Email:	Email:		
PRIMARY CONTACT NAME:	Phone:		

CLIENT INFO

CUSTODY: ☐ 2 Parent ☐ Single Parent/Mom ☐ Single Parent/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: ☐ SELF | Phone:

Position: | Agency: | MCFD Office Code:

Open file with MCFD? ☐ *yes* ☐ *no* | Does social worker want contact with counsellor? ☐ *yes* ☐

Email:

As a result of COVID-19, are you experiencing: *(please check all that apply)*

☐ Isolation ☐ Difficulty Sleeping ☐ Issues with Family /Issues with Friends
☐ Sadness ☐ Uncontrollable Worries ☐ Other: *(Please Explain)*

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

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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