

COUNSELLING REFERRAL FORM

DATE MONTH CHILD/YOUTH'S NAME: Gender: Age: DOB: _ Child/Youth's Cell #: School: Sibling Name: Gender: Age: DOB: Sibling Name: DOB: Gender: Age: 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?: Nο Guardian(s)(if applicable): Home Phone #: Work #: CELL #: EXT: Address: City: Postal Code: Email: Email: PRIMARY CONTACT NAME: Phone: **CUSTODY**: 2 Parent SP/mom SP/dad Co-parents (*joint*) In Care With relative With friend Independent living Family informed of referral and contents? DO NOT CONTACT PARENT(S): yes no Language spoken at home: Previous Cameray involvement?: *yes* no Cameray Program(s) and date(s): NAME OF REFERRING INDIVIDUAL: SELF | Phone: Position: MCFD Office Code: Agency: Open file with MCFD? yes no Does social worker want contact with counsellor? \square yes \square no Email: CYMH Referral Type: C&Y Community **PROGRAM:** BRIEF (up to 8 sessions; immediate): Brief Family (MCFD only)

Brief Sexual Abuse Counselling LONG TERM (up to 12 sessions; waitlist): Family Program Sexual Abuse Intervention (SAIP) Trauma (MCFD only) High-Risk Youth (Immediate; MCFD only) Sexual Health Intervention (SHIP) OTHER: PRESENTING PROBLEM: *If Referral is related to a non-sexual based Mental Health involvement: crime, was the client interviewed by Police? Other referrals made: Crime Victim Assistance Program Funding: yes no in process no yes contact name: Has the child/youth been diagnosed or suspected of any of the following: FASD ASD Speech & Language Disorder Intellectual Disability Other Neurodevelopment Disorders: If Sexual Abuse Program, please state what was reported, to whom, and the approximate date: Was child interviewed by MCFD? ves no **Contact Names:** no **Contact Names:** Priority Approved by: Referral taken Program Assigned: OFF<u>ICE</u> USE ONLY

5623 Imperial Street, Burnaby BC. V5J 1G1 Admin Office: #102 - Program Office: #203

On computer Referral No:

Counsellor Assigned:

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

Closing Date:

Date File Opened: