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**SEXUAL ABUSE TREATMENT PROGRAM**

**REFERRAL FORM**

**Referral Process:** Individual, parent/guardian, social worker, etc. to complete this form and return to:

Knowles Centre

Sexual Abuse Treatment Program

2065 Henderson Highway

Winnipeg, MB R2G 1P7

Phone: 204-339-1951 ext. 151

Fax: 204-334-4173

Email: SATP@knowlescentre.org

**Date of Referral:** .

**A. CLIENT REFERRAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | . | Birth date: | . |
| Address | . |
| Phone: | . | Email: | . |

Reason for Referral:(Please complete one form per individual requesting therapy)

|  |  |  |
| --- | --- | --- |
| [ ]  Child victim | [ ]  Sibling | [ ]  Non-offending parent/caregiver |

Eligibility for Criminal Injuries Funding:

|  |  |  |
| --- | --- | --- |
| [ ]  Yes | [ ]  No | [ ]  Not available |

If No or Not Available, please explain why:

.

Source of Referral:

|  |  |
| --- | --- |
| Name: | . |
| Organization: | . | Office/Unit: | . |
| Phone: | . | Email: | . |

**B. INFORMATION ON CLIENTS UNDER AGE 18**

|  |  |  |
| --- | --- | --- |
| CFS Status: | [ ]  Not in care | [ ]  Under Apprehension |
| [ ]  Voluntary Placement Agreement | [ ]  Temporary Ward | [ ]  Permanent Ward |

|  |  |  |
| --- | --- | --- |
| Custodial parent or caregiver information: |  | CFS agency information, if applicable: |
| Name of caregiver or custodial parent: | . |  | CFS worker: | . |
| Caregiver relationship to youth: | . |  | Agency: | . |
| Is parent/caregiver aware of referral? | [ ]  Yes [ ]  No |  | Address: | . |
| Phone if different than above: | . |  | Phone: | . |
| Work phone: | . | Fax: | . |
| Email: | . |  | Email: | . |

If not in care, are client’s parent(s):

|  |  |  |
| --- | --- | --- |
| [ ]  Single parent | [ ]  Common-law | [ ]  Married |
| [ ]  Separated | [ ]  Divorced | [ ]  Widowed |

What is the custody agreement between single, separated or divorced parents?

.

**C. SEXUAL ASSAULT INFORMATION**

1. Describe the details of the sexual assault (frequency, duration, severity, etc.):

.

1. Disclosure Information
2. Date of disclosure:

|  |
| --- |
| . |

1. Who disclosed:

|  |
| --- |
| . |

1. To whom disclosure made:

|  |
| --- |
| . |

1. What precipitated the disclosure?

|  |
| --- |
| . |

1. Offender Information
2. Relationship of child victim to offender:

|  |
| --- |
| . |

1. Was offender an adult or minor at the time of assault?

|  |
| --- |
| . |

1. Offender’s present/possible access to child:

|  |
| --- |
| . |

1. Medical findings, if any:

|  |
| --- |
| . |

1. Legal Status
2. Police report:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Yes, list date: | . | [ ]  No | [ ]  Pending |

1. Investigation:

Is the investigation is complete?

|  |
| --- |
| [ ]  Yes |
| [ ]  No(list reasons) | . |

1. Charges:

|  |  |
| --- | --- |
| [ ]  Yes(list charges) | . |

|  |  |
| --- | --- |
| [ ]  No(list reasons) | . |

1. Conviction:

|  |  |
| --- | --- |
| [ ]  Yes(list convictions) | . |

|  |  |
| --- | --- |
| [ ]  No(list reasons) | . |

1. Legal Counsel:

Are you represented by legal counsel for matters pertaining to the alleged sexual abuse?

|  |  |
| --- | --- |
| [ ]  Yes(provide name of counsel and contact info) | . |

|  |  |
| --- | --- |
| [ ]  No(list reasons) | . |

Are you represented by legal counsel for matters other than sexual abuse?

|  |  |
| --- | --- |
| [ ]  Yes(provide reasons, name of counsel, and contact info) | . |
| [ ]  No |

**D. REASON FOR REFERRAL**

1. List any relevant symptoms the client is experiencing (e.g., sleep, appetite, or concentration problems, regressive behaviours, etc.):

|  |
| --- |
| . |

1. List any medical or psychiatric diagnoses:

|  |
| --- |
| . |

1. List any medication currently prescribed:

|  |
| --- |
| . |

1. History of self-injurious behaviour by client

Isolated suicidal thoughts: [ ]  Yes [ ]  No

Frequent, persistent suicidal thoughts: [ ]  Yes [ ]  No

Threatening suicide: [ ]  Yes [ ]  No

Has suicide plan: [ ]  Yes [ ]  No

Risk: [ ]  High [ ]  Medium [ ]  Low

1. List any other self-injurious behaviours:

|  |
| --- |
| . |

1. List present source of treatment (e.g., family doctor, psychiatrist, therapist, etc.):

|  |
| --- |
| . |

**E. FAMILY INFORMATION**

1. List of household members:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | Age |  | Relationship |
| . |  | . |  | . |
| . |  | . |  | . |
| . |  | . |  | . |
| . |  | . |  | . |
| . |  | . |  | . |
| . |  | . |  | . |

1. Other significant family members not listed above:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | Age |  | Relationship |
| . |  | . |  | . |
| . |  | . |  | . |
| . |  | . |  | . |
| . |  | . |  | . |
| . |  | . |  | . |
| . |  | . |  | . |

1. Response of family to disclosure and current coping:

|  |
| --- |
| . |

1. List other agencies presently involved with the case:

|  |
| --- |
| . |

1. Strengths of child and/or family:

|  |
| --- |
| . |

**F. DECLARATION**

**I hereby declare that the above information is accurate.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| . |  |  |  | . |
| Print Name(Referring Individual, parent, social worker, etc.) |  | Signature |  | Date |
|  |  |