Prevention
Education
Advocacy
Counselling
Empowerment

PEACE PROGRAM
Referral Screening

options COMMUNITY SERVICES

Date of Referral: _____

Referring Source Contact

Referring Source: ☐ MCFD/Delegated office ☐ CYMH ☐ School ☐ Community Service Agency ☐ Other: _____

Contact Person: _____ Position: _____

Phone #: Email:

Please confirm the following information for the child/youth:

- ☐ The child/youth is aged 3-18
- ☐ The alleged abusive adult **DOES NOT** live in the family home
- ☐ There are no serious concerns related to suicidal ideation or self harming behaviours
- ☐ The child/youth is not currently seeking services for mental health concerns/diagnoses
- ☐ There are no concerns that the child/youth has experienced sexual abuse
- ☐ There is no indication that the child/youth needs or wants therapeutic clinical counselling

Child/Youth Information

Name: _____ D.O.B. _____ Age: _____

Name of primary caregiver: _____

Relationship to child/youth: _____

Phone number: _____

Address: _____

Guardian's name (if different from primary caregiver): _____ Phone #: _____

Guardian's relationship with child: _____

Primary language spoken by child: _____

Primary language spoken by primary caregiver:

Exposure to Intimate Partner Violence

Has been witness to or exposed to intimate partner violence: ☐ Physical ☐ Emotional

When did the separation with the alleged abuser take place? _____

Name of the alleged abusive adult and relationship to child/youth: _____

What parenting time does the alleged abusive adult have with the child/youth (days of week, frequency, hours of visits, etc.):

Service Delivery Focus

Which of the following topics would be most beneficial for the child/youth to learn more about?

☐ Feelings	☐ Safety	☐ Communication Skills	☐ Teen Dating Violence
☐ Anger	☐ Coping Skills	☐ Healthy Relationships	☐ Healthy Expression of Anger
☐ Abuse	☐ Problem Solving	☐ Self-Esteem/Self Care	