



KNOWLES CENTRE INC.

Helping Individuals Find Their Path: Yesterday, Today, and Tomorrow

**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
- Voluntary Placement Agreement
- Under Apprehension
- Temporary Ward
- Permanent Ward

Custodial parent or caregiver information:

Name of caregiver or custodial parent: _____
Caregiver relationship to youth: _____
Is parent/caregiver aware of referral? Yes No
Phone if different than above: _____
Work phone: _____
Email: _____

CFS agency information, if applicable:

CFS worker: _____
Agency: _____
Address: _____
Phone: _____
Fax: _____
Email: _____

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

- Single parent
- Separated
- Common-law
- Divorced
- Married
- 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.):

2. Disclosure Information

a) Date of disclosure: _____

b) Who disclosed: _____

c) To whom disclosure made: _____

d) What precipitated the disclosure?

3. Offender Information

a) Relationship of child victim to offender:

b) Was offender an adult or minor at the time of assault?

c) Offender's present/possible access to child:

4. Medical findings, if any:

5. Legal Status

a) Police report:

Yes, list date: _____ No Pending

b) Investigation:

Is the investigation is complete?

Yes | No (list reasons) |

c) Charges:

Yes (list charges)

No (list reasons)

d) Conviction:

Yes (list convictions)

No (list reasons)

e) 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.):

- 2. List any medical or psychiatric diagnoses:

- 3. List any medication currently prescribed:

- 4. History of self-injurious behaviour by client

Isolated suicidal thoughts:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Frequent, persistent suicidal thoughts:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Threatening suicide:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has suicide plan:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Risk:	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low

- 5. List any other self-injurious behaviours:

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

E. FAMILY INFORMATION

1. List of household members:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Other significant family members not listed above:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

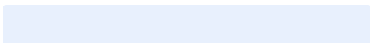
3. Response of family to disclosure and current coping:

4. List other agencies presently involved with the case:

5. 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