Department of Child and Family Services
GOVERNMENT OF BERMUDA
Ministry of Social Development & Sports
Department of Child and Family Services

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REFERRAL FORM

Referral is for : Child Protection ☐ Counselling and Life Skills ☐

The Children Act 1998
Mandatory Reporting of child Abuse : Section 20 (1)
Every person who has information indicating that a child is suffering or has suffered significant harm, shall forthwith report that information to the Director of Child and Family Services. Professionals are mandated to report and can be fined or imprisoned if they fail to report.

CHILD'S NAME: _____ **SURNAME** _____ **FIRST NAME:** _____ **MIDDLE NAME**

SEX ☐**M** ☐**F** **DOB:** _____ **MM/DD/YYYY**

Bermudian: ☐**Yes** ☐**No**

Address: _____
Cell# _____ **Email:** _____
School: _____ **YEAR LEVEL:** _____
Medical History: _____
Psychological/Psychiatric History: _____
Is the child presently taking any medication: ☐**Yes** ☐**No**
If yes, what medications: _____

Child Lives with (check all that apply): ☐ **Mother** ☐ **Father** ☐ **Legal Guardian**

Father Name: _____ **DOB:** _____ MM/DD/YYYY **Address:** _____ _____ **Place of Employment:**_____ **Home#** _____ **Work #** _____ **Cell#** _____ **Email:** _____	**Mother Name:**_____ **DOB:** _____ MM/DD/YYYY **Address:** _____ _____ **Place of Employment:**_____ **Home#** _____ **Work #** _____ **Cell#** _____ **Email:** _____

Male Legal Guardian: **DOB:** _____ MM/DD/YYYY **Relationship to Child:** _____ **Name:** _____ **Address:** _____ _____ **Place of Employment:** _____ **Home#** _____ **Work #** _____ **Cell#** _____ **Email:** _____	**Female Legal Guardian:** **DOB:** _____ MM/DD/YYYY **Relationship to Child:** _____ **Name:** _____ **Address:** _____ _____ **Place of Employment:** _____ **Home#** _____ **Work #** _____ **Cell#** _____ **Email:** _____

SIBLINGS:

Name:	DOB: MM/DD/YYYY	School:	Lives with Child Yes or No?
_____	_____	_____	☐Yes ☐No
_____	_____	_____	☐Yes ☐No
_____	_____	_____	☐Yes ☐No
_____	_____	_____	☐Yes ☐No
_____	_____	_____	☐Yes ☐No
_____	_____	_____	☐Yes ☐No

REASON FOR REFERRAL: **(Please check all areas that apply and give a written account of your observations. Indicate the nature and extent of any injuries, behavioural indicators, frequency, other relevant circumstances etc)**

Is the family aware of referral? ☐**Yes** ☐**No**

Does family agree with referral? ☐**Yes** ☐**No**

Child Protection:

- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Neglect
- ☐ Emotional Abuse
- ☐ Behaviour Problem
- ☐ Other:_____

Request for Services:

- ☐ Resource Management (Housing, Finances, budgeting)
- ☐ Child Substance Misuse Counselling/Education
- ☐ Behaviour Problem
- ☐ Gang Involvement
- ☐ Court
- ☐ Other:_____

Presenting Problem:

Please list any agencies already involved with this family.

Child's Disclosure:

Other Relevant Information /History:

Referred by: _____ **Agency:** _____

Signature:_____

Tele# : _____ ***Fax #:*** _____

Email: _____

Referral made to: _____ **Date of Referral:** Click here to enter a date.

FOR OFFICE USE ONLY:

Screened: ☐ **In** ☐ **Out**

Screened in to:

Date Referral received:_____

☐ **Investigations**
☐ **Assessment**
☐ **Family Preservation**
☐ **CLS**
☐ **High Risk**

COMMENTS:

_____
_____
_____

Screener: _____ **Coordinator/Supervisor:**_____

Assigned Social Worker:_____ **Date:** _____