



**REFERRAL FORM**

Services provided to children under age 18

*This form gives permission for the Child Witness Centre to contact you, and to notify the Crown Attorney's office of your involvement with the Child Witness Program*

111 Duke St. E.  
Kitchener, ON N2H 1A4  
Phone: 519-744-0904  
Toll-free: 1-888-544-0904  
Fax: 519-744-5379  
admin@childwitness.com

**ONCE COMPLETED, FORWARD TO THE ADDRESS/FAX/E-MAIL LISTED ABOVE**

PLEASE INDICATE:  VICTIM  WITNESS    Legal Sex:  F  M    Gender:  F or  M or  Identify as: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

PHONE #: \_\_\_\_\_ ALTERNATE #: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_

Is Parent/Guardian aware of child/youth's involvement in this matter?     YES     NO

ARE THERE OTHER YOUNG VICTIMS/WITNESSES?     NO     YES → PLEASE COMPLETE ANOTHER CONSENT FORM

INVESTIGATING OFFICER: \_\_\_\_\_ BADGE #: \_\_\_\_\_

POLICE SERVICE:     WRPS     GPS     OPP     OTHER \_\_\_\_\_

PHONE #: \_\_\_\_\_ EXTENSION: \_\_\_\_\_

ACCUSED NAME: \_\_\_\_\_

ACCUSED DATE OF BIRTH: \_\_\_\_\_ ACCUSED LEGAL SEX:     F     M

RELATION TO VICTIM/WITNESS:     PARENT     STEP-PARENT     ACQUAINTANCE  
 STRANGER     OTHER (PLEASE INDICATE) \_\_\_\_\_

CHARGE(S): \_\_\_\_\_

Is this a domestic violence matter?     Yes     No

OCCURRENCE DATE: \_\_\_\_\_ OCCURRENCE NUMBER: \_\_\_\_\_

DATE OF FIRST/NEXT COURT APPEARANCE: \_\_\_\_\_

ICON #: \_\_\_\_\_

Has this matter been reported to Family & Children's Services?     Yes     No

\_\_\_\_\_  
SIGNATURE OF CHILD (IF 12 YEARS AND OVER)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
VERBAL CONSENT - NAME

\_\_\_\_\_  
DATE