



REFERRAL FORM

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

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/VWAP of your involvement with the Child Witness Program

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: _____
(FIRST) (LAST) (mm/dd/yy)

ADDRESS: _____ CITY: _____

PHONE #: _____ ALTERNATE #: _____ POSTAL CODE: _____

E-MAIL: _____

PARENT/GUARDIAN NAME: _____
(FIRST) (LAST)

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 REFERRAL FORM

INVESTIGATING OFFICER: _____ BADGE #: _____

POLICE SERVICE: WRPS GPS OPP OTHER _____

PHONE #: _____ EXTENSION: _____

ACCUSED NAME: _____
(FIRST) (LAST)

ACCUSED DATE OF BIRTH: _____ ACCUSED LEGAL SEX: F M
(mm/dd/yy)

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

CHARGE(S): _____
Is this a domestic violence matter? Yes No

DATE CHARGES LAID: _____
(mm/dd/yy)

OCCURRENCE DATE: _____ OCCURRENCE NUMBER: _____

DATE OF FIRST/NEXT COURT APPEARANCE: (Required) _____
ICON #: _____ (mm/dd/yy)

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

_____ If verbal agreement only, check box:

SIGNATURE OF CHILD (IF 12 YEARS AND OVER)

_____ DATE (mm/dd/yy)

_____ If verbal agreement only, check box:

SIGNATURE OF PARENT/GUARDIAN

_____ DATE (mm/dd/yy)