



Adolescent Programme

P O Box 6236
Contact:
Phone:
Fax:
Email:

Christchurch. 8442
Maureen Lorimer
(03) 374 5010
(03) 374 9030
maureen@stop.org.nz

REFERRAL FORM

Date Referred

CLIENT INFORMATION

Given Name Family Name
Date of Birth Age
Ethnicity Iwi

PARENTS / GUARDIANS NAMES

Names: Phone:
Address

CAREGIVERS (if different)

Names: Phone:
Address

PERSON CLIENT IS CURRENTLY LIVING WITH

SIBLINGS/OTHER CHILDREN LIVING WITH CLIENT

Name Age Gender Living with Client
Name Age Gender Living with Client
Name Age Gender Living with Client
Name Age Gender Living with Client
Name Age Gender Living with Client
Name Age Gender Living with Client
Relationship Phone Living with Client

REFERRAL SOURCE

Name _____ Postal Address _____
Agency _____
Phone _____ Fax _____
Email: _____

LEGAL STATUS

Youth Justice FGC (Date) _____ Youth Court (Date) _____
Care / Protection FGC (Date) _____ District High Court _____
Charge Laid (specify) _____

PROBLEM BEHAVIOURS

Outline history of the following problem behaviours (include when and where displayed):

Sexually abusive behaviours:

(Include ages and relationships of victims and details / reports of any assessment / treatment services)

Self harm and / or suicide attempts:

Violence:

Alcohol and drug use:

Behaviours related to psychiatric disorder:

Other behaviours of concern

OTHER AGENCIES INVOLVED

(include reasons for referral / date / outcome)

Contact Person	_____	_____
Agency	_____	_____
Phone	_____	_____
Reason for referral	_____	_____
Date	_____	_____
Outcome (Attach report)	_____	_____

Education

Current School	_____
Contact Person (Role)	_____
Phone/Fax	_____
Level	_____

School attendance history, including number of schools attended:

History of SES involvement *(please include copies of reports):*

Key Contact Person	_____
Phone / Fax	_____
IQ Assessment level (if relevant)	_____

Family / Whanau Information

(Include any reports / summaries of Family / Whanau history)

Quality of relationships of young person with key family / whanau members:

History of CYFS / Iwi Social Services involvement with family / whanau:

Family / whanau issues pertinent to referral

(please include psychiatric, legal and abuse issues):

Placement History

(including residential, foster care, extended families) -

Medical

Current GP Name _____
Address _____
Phone / Fax _____

Significant medical history

(eg., allergies, asthma, epilepsy, disabilities, specialist reports):

Formal Reports & Records Checklist

It is important that you ensure copies of the following reports and records (if in existence) are attached to this referral (Please tick box).

- Police Summary of Facts
- Evidential interview reports
- CYFS / Iwi Social Services reports
- Family Group Conference Outcome
- Assessment / Treatment reports
- Medical specialists report
- Psychiatric / Psychological reports
- Educational / SES reports

PRIVACY ACT

By signing this form, parents/guardians and adolescent client are giving permission for information to be used for the following purposes:

- By Staff of the STOP Adolescent Programme for the purposes of the service delivery.
- Information may be shared with other professionals where it is considered to be in the best interests of the individual concerned and for matters of safety.
- Existing information held by the STOP Adolescent Programme as a result of earlier consultations may also be used to help provide appropriate services.
- Funding agencies may also have access to clients files from time to time for purposes of clinical audits.

Please forward this referral form and the information requested above to:-

Maureen Lorimer
Clinical Team Leader
STOP Adolescent Programme
P. O. Box 6236
Upper Riccarton 8442
CHRISTCHURCH

Phone (03) 374 5010
Fax (03) 374 9030
Email: maureen@stop.org.nz

Signature of client

Date

Signature of parent or legal guardian

Date