

STOP ► PO Box 6236 ► Upper Riccarton, ChCh 8442
► Phone 03 374 5010 ► Fax: 03 374 9030 ► Email: nicholas@stop.org.nz

Adult Programme

Please tick (✓) appropriate box

Referral for Treatment	<input type="checkbox"/>	
Referral for Risk Assessment	<input type="checkbox"/>	Child Youth & Family <u>Only</u>

Date Referred _____

CLIENT DETAILS

Given Name	_____	Family Name	_____
Address	_____ _____	Ethnicity	_____
	_____	Iwi	_____
Phone (home)	_____	Mobile	_____
Date of Birth	_____	Age	_____

SIGNIFICANT OTHER

Names: _____ Phone: _____
Address _____

CURRENTLY LIVING WITH (if different)

Names: _____ Phone: _____
Address _____

CHILDREN LIVING WITH CLIENT

(or likely to, in new living situation i.e. released from prison etc)

Name	_____	Name	_____
Age	_____	Age	_____
Gender:	_____	Gender:	_____
Living with Client	Yes <input type="checkbox"/> No <input type="checkbox"/>	Living with Client	Yes <input type="checkbox"/> No <input type="checkbox"/>

Name	_____	Name	_____
Age	_____	Age	_____
Gender:	_____	Gender	_____
Living with Client:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Living with Client	Yes <input type="checkbox"/> No <input type="checkbox"/>

OTHER SIGNIFICANT PERSONS

Name:	_____	Name:	_____
Address	_____	Address	_____
Relationship	_____	Relationship	_____
Phone	_____	Phone	_____
Living with Client	Yes <input type="checkbox"/> No <input type="checkbox"/>	Living with Client	Yes <input type="checkbox"/> No <input type="checkbox"/>

SUPPORT PERSONS

Please note that for the referred client to be eligible to commence treatment at the STOP Programme they must nominate at least one but preferably two or more support person/s who are assessed by the STOP programme as appropriate.

“Support person” could be the referred client's partner (if appropriate), family member, friend, church person (pastor, minister, priest), mental health professional or other persons who would be willing to support the client throughout the entire treatment at the STOP Programme. If the referred client is not willing or able to identify at least one support person they will not be able to commence treatment at STOP. Furthermore, if the referred client is not able to find such a person over the 3 months since they were offered a place in the programme, they are likely to lose the place in the treatment group. In order to re-gain access to treatment they would need to be re-referred to the STOP programme in order to undergo assessment of suitability for treatment.

Support people must attend Partner-Significant Other Education Group

SUPPORT PERSONS continued

Name: _____
Address _____
Relationship _____
Phone _____
Living with Client Yes No

Name: _____
Address _____
Relationship _____
Phone _____
Living with Client Yes No

Name: _____
Address _____
Relationship _____
Phone _____
Living with Client Yes No

Name: _____
Address _____
Relationship _____
Phone _____
Living with Client Yes No

Name: _____
Address _____
Relationship _____
Phone _____
Living with Client Yes No

Name: _____
Address _____
Relationship _____
Phone _____
Living with Client Yes No

REFERRAL SOURCE

Name _____
Agency _____
Phone _____
Email: _____

Address _____
Fax _____

Has a notification been made to Child Youth and Family Services, please provide details of this. If a notification has not been made, please provide details of why not?

LEGAL STATUS

SED (Date) _____ PED (Date) _____

Nature of sentence _____ District High Court _____

Charge Laid (specify) _____

**DETAILED HISTORY OF SEXUALLY ABUSIVE BEHAVIOUR
(including convictions)**

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

Was a referral made or treatment received at the STOP Adolescent Programme? **Yes** **No**

Violent nature

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

Convictions / charges / allegations for any other offences

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

SELF HARM AND / OR SUICIDE ATTEMPTS

(reports of any assessment / treatment services)

ALCOHOL AND DRUG USE

(reports of any assessment / treatment services)

BEHAVIOURS RELATED TO PSYCHIATRIC / PSYCHOLOGICAL DISORDER

(reports of any assessment / treatment services)

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 / EMPLOYMENT

Current Employment situation _____

Contact Person (Role) _____

Phone/Fax _____

Last year of schooling completed _____

INTELLECTUAL DISABILITY ASSESSMENT

IQ Assessment level (if relevant)

FAMILY / WHANAU INFORMATION

Quality of relationships with key family / whanau members:

MEDICAL

Current GP Name _____
Address _____
Phone / Fax _____

Significant medical history
(for example – head injury)

MOTIVATION

In your opinion, how motivated is this person to address their sexual offending over a 12 month programme

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-contemplation	Contemplation	Determination	Action

What evidence is there of this motivation?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____

FUNDING

Please advise how funding will be accessed for this referral.

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 | <input type="checkbox"/> |
| Judge's Sentencing Notes | <input type="checkbox"/> |
| Victim Impact Report / s | <input type="checkbox"/> |
| Assessment / Treatment Report / s | <input type="checkbox"/> |
| Medical Specialist / s Report | <input type="checkbox"/> |
| Psychiatric / Psychological Report / s | <input type="checkbox"/> |
| Restorative Justice Note / s | <input type="checkbox"/> |
| STOP Adolescent notes | <input type="checkbox"/> |

PRIVACY ACT

By signing this form, the client is giving permission for information to be used for the following purposes:

- By staff of the STOP Adult 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 Adult Programme as a result of earlier consultations may also be used to help provide appropriate services.
- Funding agencies may also have access to client's files from time to time for purposes of clinical audits.

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

Nicholas Hughes
Clinical Team Leader (Adult Programme)
STOP
P O Box 6236
Upper Riccarton
CHRISTCHURCH 8442

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

Signature of client

Date