



STOP Trust ▶ PO Box 13 502 ▶ Christchurch ▶ Phone 03 374 5010 ▶ Fax: 03 374 9030 ▶ Email: rashi@stop.org.nz
Adult Programme

Please tick (✓) appropriate box

Referral for Treatment	<input type="checkbox"/>
Referral for Risk Assessment	<input type="checkbox"/>

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 _____ Gender: _____	Age _____ 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 _____ Gender: _____	Age _____ 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 / SUPPORT 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"/>

REFERRAL SOURCE

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

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

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:-

Rashi Gadekar
Clinical Team Leader (Adult Programme)
STOP Trust
P O Box 13502
ARMAGH 8031
CHRISTCHURCH

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

Signature of client

Date