

STOP Adult Services PO Box 9158 Tower Junction Christchurch 8149
 ▶ Phone 03 339 4567 ▶ Email: info@stop.org.nz

Adult Programme

Please tick (✓) appropriate box

Referral for Treatment		
Referral for Risk Assessment		Oranga Tamaraki <u>Only</u>

Date of Referral _____

REASON FOR REFERRAL

Please explain the reasons why you are referring this client to our services:

CLIENT DETAILS

Given Name	_____	Family Name	_____
Address	_____	Ethnicity	_____
		Iwi	_____
Phone (home)	_____	Mobile	_____
Date of Birth	_____	Age	_____
Alias or other names used: _____			

REFERRAL SOURCE

Name	_____	Email	_____
Agency	_____	Address	_____
Relationship	_____	Fax	_____
Phone	_____		_____

SPOUSE/PARTNER

Names: _____ Phone: _____
Address _____ Relationship: _____

DOES CLIENT HAVE CHILDREN YES NO

If yes:

Name _____ Name _____
Age _____ Gender: _____ Age _____ Gender: _____
Living with Client Yes No Living with Client Yes No

DOES CLIENT HAVE CONTACT WITH ANY OTHER CHILDREN e.g. stepchildren, grandchildren, nieces, nephews YES NO

If yes:

Name _____ Name _____
Age _____ Gender: _____ Age _____ Gender: _____
Living with Client Yes No Living with Client Yes No

OTHER FAMILY MEMBERS

Names: _____ Phone: _____
Address _____ Relationship: _____

Names: _____ Phone: _____
Address _____ Relationship: _____

OTHER SIGNIFICANT PERSONS

The STOP assessment process involves collating information from a variety of relevant sources. There may therefore be other individuals besides family members whom it would be helpful for STOP to speak to as part of the assessment process. Examples of such people could include, close friends, an ex partner, a person who supervises access time with children or a counsellor or other professional. Please include details here of any such relevant people.

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

WHO IS CLIENT CURRENTLY LIVING WITH

Names: _____
Address _____

Phone: _____
Relationship: _____

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 considered by the STOP programme as appropriate. A support person needs to be in addition to the referrer.

“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.

Support Persons

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
- Judge's Sentencing Notes
- Victim Impact Report/s
- Assessment /Treatment Report/s
- Medical Specialist/s Report
- Psychiatric/Psychological Report/s
- Restorative Justice Note/s
- STOP Adolescent notes

OTHER AGENCIES INVOLVED

(include reasons for referral / date / outcome)

Contact Person _____

Agency _____

Phone _____

Date _____

Reason for referral _____

Any current/previous police or DIA involvement? Y N

If YES please indicate current legal status:

- under investigation
- charged/on bail
- charges dropped/no charges laid
- convicted and awaiting sentence
- sentenced

Description of Charges: _____

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)

ANY KNOWN MENTAL HEALTH ISSUES

(please specify any diagnosis, treatment, reports available)

OTHER BEHAVIOURS OF CONCERN

EMPLOYMENT

Current Employment Status: _____

Occupation: _____

INTELLECTUAL DISABILITY ASSESSMENT

MEDICAL HISTORY THAT MAY IMPACT ON ABILITY TO ATTEND/ENGAGE IN TREATMENT

(for example – head injury, epilepsy)

MOTIVATION

In your opinion, how motivated is this person to address their sexual offending and engage in a 12 month treatment programme?

Pre-contemplation

Contemplation

Determination

Action

What evidence is there of this motivation?

1

2

3

4

5

6

7

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 Services 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 Services 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:-

Elizabeth Scott, Team Leader
STOP Adult Services
PO Box 9158
Tower Junction
CHRISTCHURCH 8149

Phone: (03) 339 4567
Email: info@stop.org.nz

Signature of client

Date