PO Box 26130 North Avon
Christchurch 8148
Contact: Louise Wolff
Phone: (03) 353 0257
Email: louisew@stop.org.nz

stop
A Community Free From Sexual Abuse
He Hapori Waatea I Taitookai

Girls' Service

REFERRAL FORM

Date Referred _____

CLIENT INFORMATION

Given Name _____ Family Name _____

Date of Birth _____ Age _____

Ethnicity _____ Iwi _____

PARENTS / GUARDIANS NAMES

Names _____ Phone _____

Address _____ Cell _____

_____ Email _____

_____

CAREGIVERS (if different)

Names _____ Phone _____

Address _____ Cell _____

_____ Email _____

_____

PERSON CLIENT IS CURRENTLY LIVING WITH _____

SIBLINGS/OTHER CHILDREN LIVING WITH CLIENT

Name _____ Name _____

Age _____ Gender _____ Age _____ Gender _____

Living with Client Yes ☐ No ☐ Living with Client Yes ☐ No ☐

Name _____ Name _____

Age _____ Gender _____ Age _____ Gender _____

Living with Client Yes ☐ No ☐ Living with Client Yes ☐ No ☐

Name _____ Name _____

Age _____ Gender _____ Age _____ Gender _____

Living with Client Yes ☐ No ☐ Living with Client Yes ☐ No ☐

OTHER SIGNIFICANT / SUPPORT PERSONS

Name _____ Name _____

Address _____ Address _____

_____ _____

Relationship _____ Relationship _____

Phone _____ Phone _____

Living with Client Yes ☐ No ☐ Living with Client Yes ☐ No ☐

REFERRAL SOURCE

Name _____ Postal Address _____

Agency _____ _____

Phone _____ _____

Email: _____ Cell _____

LEGAL STATUS

Youth Justice FGC (Date) _____ Youth Court (Date) _____

Care / Protection FGC (Date) _____ District High Court _____

Charge Laid (specify) _____

BEHAVIOURS & EXPERIENCES

Outline history of the following behaviours and experiences

Strengths:
(What are the young person's strengths?)

Harmful Sexual Behaviours:
(Include ages and relationships of victims and details / reports of any assessment / treatment services)

Concerning Sexual Behaviour:

Diagnosis of Psychiatric Disorder:
(e.g. PTSD, ADHD, Depression, Anxiety)

Self harm and / or suicide attempts:

History of Trauma:
(i.e.: experience of abuse, neglect, witnessing violence or other traumatic event)

Violence/Aggression:

Alcohol and drug use:

Quality of Peer Relationships:

Self-Care Skills:
(e.g. hygiene, level of independence)

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):

Has any family/whanau member ever been referred to the STOP Adult Service? *(please provide details):*

Placement History

(including residential, foster care, extended families)

Education

Current School

Contact Person (Role)

Phone/Email

Level

School attendance history, including number of schools attended:

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

Key Contact Person _____

Phone / Email _____

IQ Assessment Level (if relevant) _____

OTHER AGENCIES INVOLVED

(include reasons for referral / date / outcome)

Contact Person _____

Agency _____

Phone _____

Reason for referral _____

Date _____

Outcome (Attach report) _____

MEDICAL

Current GP Name _____

Address _____

Phone / Email P: E: _____

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 Girls Service 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 Girls Service 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.

It is important that this document is signed below by adolescent client and parent/caregiver or legal guardian.

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

Louise Wolff
Project Leader
STOP Girls Service
PO Box 26130
North Avon
CHRISTCHURCH 8148

Phone (03) 353-0257
Email: louisew@stop.org.nz

Signature of client	Date
Signature of parent or legal guardian	Date