



Contact:
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(03) 353 0257

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Children's Service

REFERRAL FORM

PLEASE TYPE OR PRINT CLEARLY

Date Referred

CLIENT INFORMATION

Given Name, Family Name, Date of Birth, Age, Ethnicity, Iwi

PARENTS / GUARDIANS NAMES

Names, Address, Phone, Cell, Email

Please provide your email address only if you consent to receiving STOP correspondence electronically.

CAREGIVERS (if different)

Names, Address, Phone, Cell, Email

Please provide your email address only if you consent to receiving STOP correspondence electronically.

Date of Placement:

SIBLINGS/OTHER CHILDREN LIVING WITH CLIENT

Name, Age, Gender, Living with Client (repeated for multiple siblings)

OTHER SIGNIFICANT / SUPPORT PERSONS

Name, Address, Relationship, Phone, Living with Client

REFERRAL SOURCE

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

LEGAL STATUS

Who has custody of this child? _____
Who has guardianship of this child? _____

PROBLEM BEHAVIOURS

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

Concerning sexualised behaviours:

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

Self-harm and / or suicide attempts:

Violence/Acting Out Behaviours:

Diagnosis of psychiatric disorder: (ODD, ADHD, Depression, anxiety)

Trauma (e.g abuse, neglect, witnessing violence etc.)

Other behaviours of concern:

OTHER AGENCIES INVOLVED

Contact Person _____
Agency _____
Phone _____
Reason for referral _____

Date _____

Outcome Report Attached Yes No

Education

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

School attendance history, including number of schools attended:

Problematic Sexual Behaviours observed at School

History of GSE involvement (please include copies of reports):

Key Contact Person _____
Phone /Email _____

Family / Whanau Information

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

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

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 or STOP Adolescent Service? (please provide details)

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

Placement History

(including residential, foster care, extended families)

Placement	Caregivers	Timeframe	
		From:	To:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical

Current GP Name

Address

Phone / Email

Is the GP aware of this referral? Yes No

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).

Evidential interview reports	<input type="checkbox"/>	Family Group Conference Outcome	<input type="checkbox"/>
CYFS / Iwi Social Services reports	<input type="checkbox"/>	Medical specialists report	<input type="checkbox"/>
Assessment / Intervention reports	<input type="checkbox"/>	Educational / GES reports	<input type="checkbox"/>
Psychiatric / Psychological reports	<input type="checkbox"/>	Copy of any orders to the family (e.g. trespass/protection order)	<input type="checkbox"/>

PRIVACY ACT

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

- By staff of the STOP Children's 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 Children's Services as a result of earlier consultations may also be used to help provide appropriate services.
- Auditors from funding agencies may also have access to clients' files from time to time for purposes of clinical audits.

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

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

Suzanne Alliston

Phone (03) 353 0257

Team Leader

Email: suzannea@stop.org.nz

STOP Children's Service

P. O. Box 26130, North Avon

CHRISTCHURCH 8148

Signature of parent/caregiver or legal guardian

Date