Children's Service

Contact:
Suzanne Alliston
PO Box 26130
North Avon
Christchurch 8148
Phone: **(03) 353 0257**
Email: suzannea@stop.org.nz

REFERRAL FORM

PLEASE TYPE OR PRINT CLEARLY

Date Referred ______________________________

CLIENT INFORMATION

Legal First Name *(as per birth certificate)* ____________________ Legal Surname *(as per birth certificate)* ____________________

Preferred First Name ____________________ Preferred Surname ____________________

Date of Birth ____________________ Age ____________________

Ethnicity ____________________ Iwi ____________________

PARENTS / GUARDIANS NAMES

Names: ____________________ Phone: ____________________

Address ____________________ Cell: ____________________

____________________ Email: ____________________

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

CAREGIVERS (if different)

Names: ____________________ Phone: ____________________

Address ____________________ 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 ____________________ 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 ______________________ Agency ______________________

Role ______________________ Postal Address ______________________

Phone ______________________ ______________________

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 Oranga Tamariki – Ministry for Children (OT), / 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	☐	Family Group Conference Outcome	☐
OT / Iwi Social Services reports	☐	Medical specialists report	☐
Assessment / Intervention reports	☐	Educational / GES reports	☐
Psychiatric / Psychological reports	☐	Copy of any orders to the family (e.g. trespass/protection order)	☐

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
Team Leader
STOP Children's Service
P. O. Box 26130, North Avon
CHRISTCHURCH 8148

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

______________________________ ______________________________

Signature of parent/caregiver or legal guardian **Date**