Contact: Maureen Lorimer
PO Box 26130
North Avon
Christchurch 8148
Phone: **(03) 353 0257**
Email: maureen@stop.org.nz

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

Adolescent Service

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.

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 ☐

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 _____ _____

Role _____ Email: _____

LEGAL STATUS

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

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

Charge Laid (specify) _____

PROBLEM BEHAVIOURS

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

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

Self harm and / or suicide attempts:

Violence:

Alcohol and drug use:

Behaviours related to psychiatric disorder:

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

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) _____

Family / Whanau Information

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

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

History of Ministry for Children, Oranga Tamariki (OT), 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)

Medical

Current GP Name _____

Address _____

Phone / Email _____

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 ☐

OT/ Iwi Social Services reports ☐

Family Group Conference Outcome ☐

Assessment / Intervention 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 Adolescent 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 Adolescent 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:

Maureen Lorimer
Clinical Manager
STOP Adolescent and Children's Service
PO Box 26130
North Avon
CHRISTCHURCH 8148

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

Signature of client	Date
Signature of parent or legal guardian	Date