

## ADULT SERVICE

Please tick ( ✓ ) appropriate box

Referral for Assessment of suitability for Treatment	
Referral for Risk Assessment	

**Oranga  
Tamariki  
Only**

Date of Referral \_\_\_\_\_

### REASON FOR REFERRAL

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

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Legal First Name  
(as per birth certificate) \_\_\_\_\_

Legal Surname  
(as per birth certificate) \_\_\_\_\_

Preferred First Name \_\_\_\_\_

Preferred Surname \_\_\_\_\_

Address \_\_\_\_\_

Ethnicity \_\_\_\_\_

Iwi \_\_\_\_\_

Phone (home) \_\_\_\_\_

Mobile \_\_\_\_\_

Date of Birth \_\_\_\_\_

Age \_\_\_\_\_

Alias or other names used \_\_\_\_\_

### REFERRAL SOURCE

Name \_\_\_\_\_

Email \_\_\_\_\_

Agency \_\_\_\_\_

Address \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

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**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	_____	Name	_____
Address	_____	Address	_____
	_____		_____
Relationship	_____	Relationship	_____
Phone	_____	Phone	_____
Living with Client	Yes <input type="checkbox"/> No <input type="checkbox"/>	Living with Client	Yes <input type="checkbox"/> No <input type="checkbox"/>

Name	_____	Name	_____
Address	_____	Address	_____
	_____		_____
Relationship	_____	Relationship	_____
Phone	_____	Phone	_____
Living with Client	Yes <input type="checkbox"/> No <input type="checkbox"/>	Living with Client	Yes <input type="checkbox"/> No <input type="checkbox"/>

**WHO IS CLIENT CURRENTLY LIVING WITH**

Names	_____	Phone	_____
Address	_____	Relationship	_____
	_____		
	_____	Mobile	_____

**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.



**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)*

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**Convictions / charges / allegations for any other offences**

*(Include ages and relationships of victims and details / reports of any assessment / treatment services)*

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**SELF HARM AND / OR SUICIDE ATTEMPTS**

*(reports of any assessment / treatment services)*

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**ALCOHOL AND DRUG USE**

*(reports of any assessment / treatment services)*

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**ANY KNOWN MENTAL HEALTH ISSUES**

*(please specify any diagnosis, treatment, reports available)*

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**OTHER BEHAVIOURS OF CONCERN**

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**EMPLOYMENT**

Current Employment Status \_\_\_\_\_

Occupation \_\_\_\_\_

**INTELLECTUAL DISABILITY ASSESSMENT**

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

*(for example – head injury, epilepsy)*

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**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?**

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**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 26130  
**CHRISTCHURCH 8148**

Phone (03) 353 0257  
Email [info@stop.org.nz](mailto:info@stop.org.nz)

\_\_\_\_\_  
**Signature of client**

\_\_\_\_\_  
**Date**