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

STOP Adult Services PO Box 26130 Christchurch 8148
► Phone 03 339 4567 ► Email: info@stop.org.nz

Capacity and Ability to Protect (CAP) Assessment

Date of Referral _____

CARER DETAILS

Given Name _____ **Family Name** _____
Address _____ **Ethnicity** _____
_____ **Iwi** _____
Phone (home) _____ **Mobile** _____
Date of Birth **Age** _____

REFERRAL SOURCE

Name _____ Email _____
Agency _____ Address _____
Phone _____ _____

REASON FOR REFERRAL

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

_____
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_____

SPOUSE/PARTNER

Names: _____ Phone: _____

Address _____ Relationship: _____

_____

_____

Is their partner currently attending STOP?	**YES**	/	**NO**
If no, has their partner been referred to STOP?	**YES**	/	**NO**
Has their spouse/partner attended STOP in the past?	**YES**	/	**NO**
Are they currently living with spouse/partner?	**YES**	/	**NO**
If **NO** where does the spouse/partner currently reside?			

CHILDREN AT RISK

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 ☐

Child Vulnerability Issues

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OTHER AGENCIES INVOLVED

Please provide details of any other agencies involved currently and/or historically for example Home and Family, Holly House, Mental Health agencies etc.

Please include copies of the any relevant reports/assessments where relevant/available: e.g. Family Group Conference outcome reports, Family/Whanau agreements, substance abuse assessment/intervention reports, parenting assessments etc.

Does this person have any criminal convictions?	**YES**	/	**NO**
Is there any current police involvement?	**YES**	/	**NO**
Are there any current protection orders in place?	**YES**	/	**NO**

Medical/Other information

Please provide information regarding any physical disabilities, mental health issues, level of intellectual functioning, addictions etc.

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

_____	_____
Signature of client	**Date**

Please note:

You will receive a receipt to confirm we have received your referral.
If you do not receive this within 2 working days of submitting your referral to us, please contact our offices