

REFERRAL FORM

Date Referred _____

CLIENT INFORMATION

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

PARENTS / GUARDIANS NAMES

Names _____ Phone _____
 Address _____ Cell _____
 _____ Email _____

CAREGIVERS (if different)

Names _____ Phone _____
 Address _____ Cell _____
 _____ Email _____

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

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 _____
Email: _____ Cell _____

LEGAL STATUS

Youth Justice FGC (Date) _____ Youth Court (Date) _____
Care / Protection FGC (Date) _____ District High Court _____
Charge Laid (specify) _____

BEHAVIOURS & EXPERIENCES

Outline history of the following behaviours and experiences

Strengths:

(What are the young person's strengths?)

Harmful Sexual Behaviours:

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

Concerning Sexual Behaviour:

Diagnosis of Psychiatric Disorder:

(e.g. PTSD, ADHD, Depression, Anxiety)

Self harm and / or suicide attempts:

History of Trauma:

(i.e.: experience of abuse, neglect, witnessing violence or other traumatic event)

Violence/Aggression:

Alcohol and drug use:

Quality of Peer Relationships:

Self-Care Skills:

(e.g. hygiene, level of independence)

Family / Whanau Information

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

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

History of CYFS / 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)

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) _____

OTHER AGENCIES INVOLVED

(include reasons for referral / date / outcome)

Contact Person _____
Agency _____
Phone _____
Reason for referral _____
Date _____
Outcome (Attach report) _____

MEDICAL

Current GP Name _____
Address _____
Phone / Email P: _____ E: _____

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 | <input type="checkbox"/> |
| Evidential interview reports | <input type="checkbox"/> |
| CYFS / Iwi Social Services reports | <input type="checkbox"/> |
| Family Group Conference Outcome | <input type="checkbox"/> |
| Assessment / Treatment reports | <input type="checkbox"/> |
| Medical specialists report | <input type="checkbox"/> |
| Psychiatric / Psychological reports | <input type="checkbox"/> |
| Educational / SES reports | <input type="checkbox"/> |

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 Girls 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 Girls 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:

STOP Girls' Service
PO Box 26130
North Avon
CHRISTCHURCH 8148

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

Signature of client

Date

Signature of parent or legal guardian

Date