



Contact: Betty Gallagher

PO Box 26130 North Avon Christchurch 8148

Phone:

(03) 353 0257

Email:

Betty.gallagher@stop.org.nz

Children's 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.

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	<input type="checkbox"/>	Family Group Conference Outcome	<input type="checkbox"/>
OT / Iwi Social Services reports	<input type="checkbox"/>	Medical specialists report	<input type="checkbox"/>
Assessment / Intervention reports	<input type="checkbox"/>	Educational / GES reports	<input type="checkbox"/>
Psychiatric / Psychological reports	<input type="checkbox"/>	Copy of any orders to the family (e.g. trespass/protection order)	<input type="checkbox"/>

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:-

Betty Gallagher

Team Leader

STOP Children's Service

P. O. Box 26130, North Avon

CHRISTCHURCH 8148

Phone (03) 353 0257

Email: Betty.gallagher@stop.org.nz

Signature of parent/caregiver or legal guardian

Date