STOP Adult Services PO Box 26130 North Avon Christchurch 8148
► Phone 03 353 0257 ► Email info@stop.org.nz

ADULT SERVICE

Referral for Assessment of suitability for Intervention

Date of Referral _____

REASON FOR REFERRAL

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

_____

_____

_____

_____

_____

_____

_____

_____

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 _____ _____

SPOUSE/PARTNER

Names _____ Phone _____

Address _____ Relationship _____

_____

_____

DOES CLIENT HAVE CHLDREN 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 CHLDREN

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 ☐ No ☐ Living with Client Yes ☐ No ☐

Name _____ Name _____

Address _____ Address _____

_____ _____

Relationship _____ Relationship _____

Phone _____ Phone _____

Living with Client Yes ☐ No ☐ Living with Client Yes ☐ No ☐

WHO IS CLIENT CURRENTLY LIVING WITH

Names _____ Phone _____

Address _____ Relationship _____

_____

_____ Mobile

SUPPORT PERSONS

<u>Please note</u> 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.

Support Persons

Name _____ **Name** _____

Address _____ Address _____

_____ _____

Relationship _____ Relationship _____

Phone _____ Phone _____

_____ _____

Name _____ **Name** _____

Address _____ Address _____

_____ _____

Relationship _____ Relationship _____

Phone _____ Phone _____

Has the client been referred to STOP Adult Services previously? **Y** ☐ **N** ☐

Has the client been referred to STOP Adolescent Programme previously? Y ☐ **N** ☐

Date of Referral _____ **Outcome of Referral** _____

Has a notification been made to Oranga Tamariki, please provide details of this. If a notification has not been made, please provide details of why not?

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

_____

_____

If sentenced;

- **SED** ☐
- **Home Detention** ☐
- **Intensive Supervision** ☐
- **Post Detention conditions** ☐
- **Supervision** ☐
- **Community Work** ☐
- **ESO** ☐
- **Parole** ☐
- **Post Sentence Conditions** ☐
- **Care Recipient (IDCCR)**

DETAILED HISTORY OF SEXUALLY ABUSIVE BEHAVIOUR
(including convictions)

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

Violent nature

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

Convictions / charges / allegations for any other offences

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

SELF HARM AND / OR SUICIDE ATTEMPTS

(reports of any assessment / treatment services)

ALCOHOL AND DRUG USE

(reports of any assessment / treatment services)

ANY KNOWN MENTAL HEALTH ISSUES

(please specify any diagnosis, treatment, reports available)

OTHER BEHAVIOURS OF CONCERN

EMPLOYMENT

Current Employment Status

Occupation

INTELLECTUAL DISABILITY ASSESSMENT

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

(for example – head injury, epilepsy))

MOTIVATION

In your opinion, how motivated in this person to address their harmful sexual behaviour and engage in a treatment programme?

☐ Pre-contemplation ☐ Contemplation ☐ Determination ☐ Action

What evidence is there of this motivation?

1

2

3

4

5

6 _____

7 _____

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 -

Team Leader
STOP Adult Services
PO Box 26130
North Avon
CHRISTCHURCH 8148
Phone (03) 353 0257
Email info@stop.org.nz

_____ _____

Signature of client **Date**