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)

		Timeframe	
Placement	***Caregivers***	***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	☐	Family Group Conference Outcome	☐
OT / Iwi Social Services reports	☐	Medical specialists report	☐
Assessment / Intervention reports	☐	Educational / GES reports	☐
Psychiatric / Psychological reports	☐	Copy of any orders to the family (e.g. trespass/protection order)	☐

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**