

Contact: PO Box 26130
North Avon
Christchurch 8148
Phone: (03) 353 0257
Email: info@stop.org.nz



ADOLESCENT SERVICE REFERRAL FORM

PLEASE TYPE OR PRINT CLEARLY

Date Referred _____

CLIENT INFORMATION

Legal First Name _____ Legal Surname _____
(as per birth certificate) *(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.

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

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	_____		_____
Role	_____	Email:	_____

LEGAL STATUS

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

PROBLEM BEHAVIOURS

Outline history of the following problem behaviours (include when and where displayed):

Harmful Sexual behaviours:

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

Self harm and / or suicide attempts:

Violence:

Alcohol and drug use:

Behaviours related to psychiatric disorder:

Other behaviours of concern:

OTHER AGENCIES INVOLVED

(include reasons for referral / date / outcome)

Contact Person

Agency

Phone

Reason for referral

Date

Outcome (Attach report)

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)

Family / Whanau Information

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

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

History of Ministry for Children, Oranga Tamariki (OT), 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)

Medical

Current GP Name _____

Address _____

Phone / Email _____

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"/> |
| OT/ Iwi Social Services reports | <input type="checkbox"/> |
| Family Group Conference Outcome | <input type="checkbox"/> |
| Assessment / Intervention 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 Adolescent 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 Adolescent 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:

Manager
Stop Adolescent 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