ADULT 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: _____ Gender _____

Ethnicity _____ Iwi _____

Email _____ Mobile _____

Address _____

Would the client and whānau benefit from Stop engaging a translator? Yes ☐ No ☐

Would you like support in completing this referral form? Yes ☐ No ☐

Is this a self-referral? Yes ☐ No ☐

How did you hear about Stop? _____

Referral Source

Name: _____ Phone: _____

Agency: _____ Email: _____

Role/ Relationship: _____

Please provide your email address if you consent to receiving Stop correspondence electronically.

Living & Whānau Situation

Does Client Have Children? Yes ☐ No ☐ *(If yes, please complete the below section)*

Name	***Age***	***Gender***	***Living with Client***
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

Does Client Have Contact with Other Children? Yes ☐ No ☐ *(If yes, please complete the below section)*
e.g. stepchildren, grandchildren, nieces, nephews.

Name	***Age***	***Gender***	***Relationship to Client***

Who is the Client Currently Living With?

Name _____ Phone: _____

Relationship: _____ Email _____

Name _____ Phone: _____

Relationship: _____ Email _____

Name _____ Phone: _____

Relationship: _____ Email _____

Has Oranga Tamariki ever been involved with your whānau (or the client's whānau)? Yes ☐ No ☐

Reason for Referral

Please explain why you are referring yourself (or the client) to our services:

Please provide a history of any prior harmful sexual behaviour (including convictions):

Please outline if you (or the client) have any Mental Health or Neurodevelopmental Diagnoses: *(e.g. Anxiety, ADHD, Autism, Depression, Intellectual Disability)*

Have you (or the client) ever displayed, engaged with or experienced the following:
(Please outline current, historic or Not Applicable)

Self-harm, Suicide Attempts or Suicidal Thoughts	Current ☐	Historic ☐	N/A ☐
Violence/Aggression	Current ☐	Historic ☐	N/A ☐
Experience of Trauma (e.g. abuse, neglect)	Current ☐	Historic ☐	N/A ☐
Alcohol and Drug Use	Current ☐	Historic ☐	N/A ☐
Mental Health Concerns	Current ☐	Historic ☐	N/A ☐

Additional Information

Have you (or the client) had Police or DIA involvement? Current ☐ Historic ☐ N/A ☐

If answered Current, please indicate your (or the client's) current legal status:

Under Investigation		*Charged / On Bail*	
Charges Dropped / No Charges Laid		*Convicted and Awaiting Sentence*	
Sentenced			

Please provide a description of any current charges:

If sentenced, please identify if you (or the client) are on sentence:

Home Detention / Post Detention Conditions		*Community Detention*	
Intensive Supervision		*Extended Supervision Order (ESO)*	
Supervision		*Release in Conditions (ROC)*	
Care Recipient (IDCCR Act)		*Parole*	

What is the Sentence End Date? _____

Have you (or the client) had involvement with Stop previously? Yes ☐ No ☐

Other Agencies Involved

Contact Person _____

Agency _____

Phone/ Email _____

Reason for Referral _____

_____

Employment

Employment Status _____

Occupation _____

Hours of Work _____

Medical

Current GP Name _____

Address _____

Phone / Email _____

Is there any specific medical history or conditions that Stop should be aware of?
e.g. allergies, asthma, epilepsy, food allergy/intolerance, head injury, depression, anxiety.

Formal Reports & Records Checklist

To support in our referral triaging process, please supply copies to the following reports and records (if they are available):

- Police Summary of Facts
- Judge's Sentencing Notes
- Victim Impact Reports
- Specialist Assessment/Treatment Reports
- Psychiatric/Psychological Reports
- Medical Specialists Reports
- Restorative Justice Notes

Privacy Act

By signing this form, the client or the referrer acknowledge the following and are giving permission for information to be used for the following purposes:

- By kaimahi of the Stop Adult Service for the purposes of the service triaging the referral for consideration of service delivery.
- Information may be shared with the other professionals nominated by the client or referrer within this documentation, where it is in the best interests of the individual concerned and for matters of safety.
- Existing information held by Stop as a result of earlier consultations may also be used to help provide appropriate services.
- Stop does not undertake a duty of care for you (the client) until the referral has been accepted and there is active engagement with the nominated clinician.

Consent

It is important that this document is signed below by the client and (if applicable) the referrer.

Please forward this signed referral form and the information requested above to:

Team Leader
Stop Adult Service
P. O. Box 26130, North Avon
CHRISTCHURCH 8148

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

Name of Client *(Please Print)*

Client Signature

Date

Referrer Signature

Date