ADULT SERVICE – IDEATION REFERRAL

Please Type or Print Clearly

Date of Referral _____

Client Information

Legal First Name *(as per birth certificate)*		Legal Surname *(as per birth certificate)*	
Preferred First Name		Preferred Surname	
Date of Birth		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 ☐

Have you had involvement with Stop previously? Yes ☐ No ☐

How did you hear about Stop? _____

Reason for Referral

Please explain why you are referring yourself to our services. What would you like help with?
(Please provide as much detail as you can to support our ability to provide you support)

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

Have you 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

Are there any other agencies or professionals involved in supporting you to manage your sexual thoughts or behaviours?

Yes, Current Involvement ☐ Yes, Historic Involvement ☐ No ☐

If answered yes, please provide further details:

Other Agencies Involved

Are there any other agencies or professionals involved in supporting you currently?

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.

Privacy Act

By signing this form, you acknowledge the following information 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 until the referral has been accepted and there is active engagement with the nominated clinician.

Consent

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