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: _____ Gender _____

Ethnicity _____ Iwi _____

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

PARENTS / GUARDIANS NAMES

Name: _____ Phone: _____

Address: _____ Email: _____

_____

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

Name: _____ Phone: _____

Address: _____ Email: _____

_____

_____

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

CAREGIVERS (if different)

Names: _____ Phone: _____

Address _____ Email: _____

_____

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

Date of Placement Commencement: _____

SIBLINGS/OTHER CHILDREN LIVING WITH CLIENT

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

Referral Source

Name _____ Agency _____

Role _____ Postal Address _____

Phone _____ _____

Email _____ _____

How did you hear about Stop? _____

Legal Status

Who has custody of this child? _____

Who has day to day care of this child? _____

Reason for Referral

Concerning Sexualised Behaviours:
(Include ages and relationships with tamariki or individuals involved, where it occurred and details / reports of any assessment / intervention services)

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

Has there been any current or previous indication of the following:

Self-harm, Suicide Attempts or Suicidal Thoughts Yes ☐ No ☐

Aggression/Acting Out Behaviours Yes ☐ No ☐

Experience of Trauma (e.g. abuse, neglect) Yes ☐ No ☐

Other Agencies Involved

Contact Person _____

Agency _____

Phone _____

Reason for Referral _____

Education

Current School/Kura _____

Contact Person (Role) _____

Phone / Email _____

Is the School aware of this referral? Yes ☐ No ☐

Placement History

(Including Residential, Foster Care, Extended Family, Whānau, Whangai)

Placement	***Caregivers***	***From:*** *(Dates)*	***To:***

Medical

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

Formal Reports & Records

To support in our referral triaging process, please supply copies to the following reports and records (if they are available): Child Focussed Interviews, Family Group Conference Outcome, Oranga Tamariki/ Iwi/ Social Service Reports, Psychiatric/Psychological Reports, Medical Specialists Reports, Educational Reports, Copies of any orders to the family (e.g. Trespass or Protection Order).

Privacy Act

By signing this form, parents/guardians are giving permission for information to be used for the following purposes:

- Stop does not undertake a duty of care for this tamariki until their referral has been accepted and they are actively engaged with their nominated clinician.
- By kaimahi of the Stop Children's Services 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 referrer within this documentation, where it is 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.

It is important that this document is signed below by a parent/caregiver or legal guardian.

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

Team Leader
Stop Children's Service
P. O. Box 26130, North Avon
CHRISTCHURCH 8148

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

Consent

Name of Parent/Caregiver or Legal Guardian (*Please Print)*

Signature **Date**

Referrer Signature **Date**