ADOLESCENT 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 ☐

Have the client or whānau been involved with Stop previously? Yes ☐ No ☐

Parents / Guardians

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 Tamariki Living with Client

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

Referral Source

Name _____ Postal Address: _____

Agency _____ _____

Phone _____ _____

Role _____ Email: _____

How did you hear about Stop? _____

Legal Status (If Applicable)

Youth Justice Family Group Conference (Date) _____ Youth Court (Date) _____

Care/Protection FGC (Date) _____ District High Court _____

Specify any Charges Laid _____

_____

Reason for Referral

Harmful Sexual Behaviour(s):
(Include ages and relationships with tamariki or individuals involved, where it occurred and details / reports of any assessment / intervention services. Including any online behaviours)

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:
(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 ☐

Other Agencies Involved

Contact Person _____

Agency _____

Phone/ Email _____

Reason for Referral _____

_____

Education

Current School/Kura _____

Contact Person (Role) _____

Phone/ Email _____

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

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.

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
- Evidential Interview Reports
- Oranga Tamariki, Iwi, or Social Service Repoers
- Family Group Conference Outcome
- Psychiatric/Psychological Reports
- Medical Specialists Reports
- Educational Reports

Privacy Act

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

- Stop does not undertake a duty of care for this rangatahi until their referral has been accepted and they are actively engaged with their nominated clinician.
- By kaimahi of the Stop Adolescent 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 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.

Consent

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

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

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

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

_____

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

_____ _____

Signature **Date**

_____

Name of Rangatahi *(Please Print)*

_____ _____

Signature **Date**

_____ _____

Referrer Signature **Date**