**TE HAPARA FAMILY SERVICES REFERRAL FORM**

(To be completed by ACW staff, self-referrer or referring agencies)

PLEASE NOTE – we are not a crisis response service. If there is immediate or significant risk of safety to self or others contact Mental Health Crisis Line 0800 243 500 OR the NZ Police OR Oranga Tamariki 0508 326 459

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| Recorded by: |  | Date: |  |
| What services are requested? |[ ]  Social Work  |[ ]  Strong Women Programme  |
|  |[ ]  Counselling |[ ]  Growing Through Grief |
|  | [ ]  | Post Natal Depression Course |[ ]  Other: *please specify*  |  |

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| **SECTION 1: CLIENT DETAILS**  |
| Client’s name: |  |
| Gender: | [ ]  M | [ ]  F | [ ]  Gender Diverse |
| Date of birth: |  | Age: |  |
| Address: |
| Email: |  |
| Home phone: |  | Mobile phone: |  |
| Permission to leave voice mail: |  [ ]  Yes |  [ ]  No |
| Permission to send TXT message: |  [ ]  Yes |  [ ]  No |
| Do you have child/ren in your care aged 0-17 years? |  [ ]  Yes |  [ ]  No |
| **Ethnicity:** Please mark those that apply [ ]  New Zealand European / Pākehā [ ]  Māori [ ]  Samoan [ ]  Cook Island [ ]  Tongan [ ]  Niuean [ ]  Indian [ ]  Chinese [ ]  Other (Please state)\*For statistical purposes always use Māori or Pacific as primary ethnicity if more than one ethnicity. |
| If the client is a child/minor, please complete the following: |
| Relationship to client | [ ]  Mother | [ ]  Father | [ ]  Other |
| Name:  |  | Date of birth:  |  |
| Address: |
| Email: |  |
| Home phone: |  | Mobile phone: |  |
| Best time to contact  | [ ]  AM | [ ]  PM |

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| **SECTION 2: FAMILY AND SIGNIFICANT OTHERS** |
| Name:  | Relationship | DOB: | Gender: | School/ECE: | Age: |
|  |  |  | [ ] M | [ ] F | [ ] NB |  |  |
|  |  |  | [ ] M | [ ] F | [ ] NB |  |  |
|  |  |  | [ ] M | [ ] F | [ ] NB |  |  |
|  |  |  | [ ] M | [ ] F | [ ] NB |  |  |
|  |  |  | [ ] M | [ ] F | [ ] NB |  |  |

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| **SECTION 3: REASON(S) FOR REFERRAL** |
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| How did you hear about us? |

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| **SECTION 4: INITIAL ASSESSMENT OF RISK** |
| Urgency of Situation: | [ ]  Urgent | [ ]  High priority | [ ]  Medium priority | [ ]  Low priority |

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| **SECTION 5: ADDITIONAL INFORMATION**  |
| Are there current or historical concerns re: family harm? |  [ ]  Yes |  [ ]  No |
| If yes, is there a current safety plan?  |  [ ]  Yes |  [ ]  No |
| If yes, please attach a copy of the safety plan |  [ ]  Attached |  [ ]  Not Attached |
| Are there any current court orders, e.g. Parenting or protection orders?  |  [ ]  Yes |  [ ]  No |
| Are there any current matters before the Court?  |  [ ]  Yes |  [ ]  No |
| Are there any concerns re: Alcohol and drug use? |  [ ]  Yes |  [ ]  No |
| Are there any concerns re: Suicidal ideation and/ or self-harming? |  [ ]  Yes |  [ ]  No |
| What other agencies are currently involved? |
| Is there a current or historical mental health diagnosis? E.g., depression, bipolar, schizophrenia? ☐ Yes ☐ NoIf yes, is this being managed with medication?  |
| Are there any special needs, disabilities, medical alerts, allergies or other medical concerns we need to be aware of? |
| GP Name:  | Contact phone: |

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| **SECTION 6: EMERGENCY CONTACT**  |
| Name: |  |
| Contact phone: |  |
| Relationship to client:  |  |

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| **SECTION 7: REFERRER DETAILS** – if self-referred this is not necessary  |
| Does the client give consent for this referral? | [ ] Yes | [ ] No |
| Referral organisation:  |  | Contact phone: |  | Mobile: |  |
| Referrer’s name: |  | Address:  |  |
| Relationship to client:  |  | Email:  |  |

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| **SECTION 8: REFERRAL SIGN OFF**  |
| Client’s/Referrer’s signature: |  | Date:  |  |

Please send to: admin.thfs@acw.org.nz