JIGSAW NORTH
manaaki whānau

Referral

Date:

Parent/caregiver (if applicable or if client is under 18 years old)	
Name:	**Relationship:**
Date of birth:	☐ **Female** ☐ **Male** ☐ **Gender diverse**
Ethnicity: *Māori, NZ European etc*	**Iwi/hapū:**

Client – who will be using the services? Eg. child, whanau member, parent.	
Name of client:	**School (if child):**
Date of birth:	☐ **Female** ☐ **Male** ☐ **Gender diverse**
Ethnicity: *Māori, NZ European etc*	**Iwi/hapū:**

Service requested:

☐ **Counselling in person OR ☐ Counselling online**
☐ **Social work**
☐ **Parenting Programme – tick ONE programme below:**
- ☐ Building Awesome Whanau: 6-week course
- ☐ Circle of Security: 8-week course
- ☐ Mai te Po ki te Ao Marama: 7/8-week course (female only)
- ☐ Teenage Years: 6-week course

For more information on our parenting programmes: www.jigsawnorth.org.nz

Contact:
Phone:
Address:
Email:

Partner/Additional children		
Partner:	**Date of birth:**	☐ **Female** ☐ **Male** ☐ **Gender diverse**
Child:	**Date of birth:**	☐ **Female** ☐ **Male** ☐ **Gender diverse**
Child:	**Date of birth:**	☐ **Female** ☐ **Male** ☐ **Gender diverse**
Child:	**Date of birth:**	☐ **Female** ☐ **Male** ☐ **Gender diverse**
Child:	**Date of birth:**	☐ **Female** ☐ **Male** ☐ **Gender diverse**
Child:	**Date of birth:**	☐ **Female** ☐ **Male** ☐ **Gender diverse**
Child:	**Date of birth:**	☐ **Female** ☐ **Male** ☐ **Gender diverse**

Additional caregiver / Emergency contact/next of kin (please circle)	
Name:	**Relationship:**
Email:	**Phone:**

Referrer Details

☐ **Myself**
☐ **Another person (name):**
Role: **Organisation:**
Phone: **Email:**

Is client aware of and gives consent to the referral? ☐ **yes** ☐ **no**

IMPORTANT INFORMATION

If this is an emergency, please call the Police 111 or crisis Mental Health Support 0800223371

You may be eligible for ACC Free Counselling if you have experienced sexual assault 0800 101996 Call ACC

Are there children under 18 years old currently in your care?	**Yes**☐ **No** ☐
How many children under 18 are in your home?	*No. of children*
If separated, is there shared guardianship/custody?	**Yes**☐ **No** ☐ If yes, please give details.
Do you have upcoming Family Court or Family Group Conference Dates (FGC)?	**Yes**☐ **No** ☐
Do you have Mental Health needs/history – diagnosed or undiagnosed? If yes, please explain.	**Yes**☐ **No** ☐
Have you experienced suicidal thoughts and/or feelings?	**Yes**☐ **No** ☐ If yes, when?
Do you have any needs that we should be aware of in our interaction with you? e.g. hearing or sight impaired.	**Yes**☐ **No** ☐ If yes, please explain.
Please list any other agencies involved:	

What is happening now? Please give us as much information as you are comfortable sharing around the reason for this referral. It will help us to triage the urgency and allocate of the referral.