

## Referral

Date: Parent/caregiver (if applicable or if client is under 18 years old) Relationship: ☐ Female ☐ Male ☐ Gender diverse Date of birth: Iwi/hapū: Ethnicity: Māori, NZ European etc 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: For more information on our parenting ☐ Building Awesome Whanau: 6-week course programmes: ☐ Circle of Security: 8-week course www.jigsawnorth.org.nz ☐ Mai te Po ki te Ao Marama: 7/8-week course (female only) ☐ Teenage Years: 6-week course **Contact:** Phone: Address: **Email:** Partner/Additional children ☐ Female ☐ Male ☐ Gender diverse Partner: Date of birth: Child: Date of birth: ☐ Female ☐ Male ☐ Gender diverse Child: Date of birth: ☐ Female ☐ Male ☐ Gender diverse Date of birth: Child: ☐ 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?  $\square$  yes  $\square$  no

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