



P O Box 221, Putāruru, 3443
 referral@wcswh.org.nz
www.wcswh.org.nz
 0800 843 966
 (07) 949 7542

REFERRAL FORM CONFIDENTIAL

CONSENT	
<i>Before making an interagency referral it is important that the individual/whānau being referred has been consulted and has given their consent.</i>	
Referral discussed with individual/family/whānau, and consent obtained:	Yes / No
REFERRER DETAILS	
Date:	Agency:
Name:	Phone:
Email:	

CLIENT DETAILS			
First Name:		Family Name:	
Known as:		Date of Birth:	
Date of Birth:		Gender:	
Ethnicity:			
If 'Māori' please specify Tribe/Iwi:			
CONTACT DETAILS			
Street Address:			
Contact Number:			
Email:			

PARENT/CAREGIVER INFORMATION <i>(If applicable)</i>	
Parent one:	
Address: <i>(If different to above)</i>	
Contact Details:	
Parent two:	
Address: <i>(If different to above)</i>	
Contact Details:	
Caregiver/Other:	
Address and Contact Details:	

STATEMENT OF CONFIDENTIALITY:

The information contained in this and any attached pages are intended to be for the use of the addressee named on the referral form. If you are not the person named on this referral form then please note that any disclosure, duplicating, distribution or use of the contents of this personal information is prohibited. If you have received this information in error, please notify us by telephone immediately so that we can arrange for the retrieval of the original document(s) at no cost to you.

PRIVACY:

When we collect, use and store information, we comply with the Privacy Act 1993 and the Health Information Privacy Code 1994.

WHĀNAU DETAILS			
Name:	Relationship:	Address:	DoB:
OTHER AGENCIES OR PROFESSIONALS INVOLVED			
Agency:	Name:	Contact:	
Brief History/Background and Reason for Referral:			
SERVICES REQUESTED			
<i>(this can be adjusted as relevant to each service/centre, for example individual, couple, family, or programme).</i>			
Social work assessment/intervention (wrap around service)			
Financial mentoring			
Parenting programme – Circle of Security			
Parenting programme – Respectful parents respectful children			
Developing effective communication skills for building relationships			
Occupational Therapy			
Male support services			
Other			
OTHER INFORMATION			
Please attach any relevant OT or FGC Report/Plan plus any additional relevant reports etc. required to deliver this intervention.			
Referral concerns (what are you concerned about?)			
Referral goals?			

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RISKS AND HAZZARDS			
Please state any concerns regarding the safety of the client at work, at home, or anyone else's (including tamariki/whānau):			
State any mental health concerns (including any risk issues or history of self-harm):			
State any significant alcohol/drug issues:			
State any current or historic concerns about relationship or family violence:			
Is there a Protection Order in place for this client or a member of the client's family? If so, name the respondent and/or name the protected person:			
Is there a Police Safety Order in place for this client?			
Detail any known hazards affecting a staff member working with this client or family alone, or visiting the client/family in their home (e.g. violence, dogs, gang issues):			
CLIENT AND/OR WHĀNAU AGREEMENT TO THE REFERRAL			
I/We give informed consent to a referral to Whānau Centred Services I/We agree for Whānau Centred Services to be invited to the FGC (if appropriate) I/We agree for information about myself and family as above to be shared with Whānau Centred Services as part of this referral. I/We agree for the following reports to be shared with Whānau Centred Services to assist them in delivering a service.			
SIGNATURES			
Client Signature:		Date:	
Parent/Caregiver Signature: <i>(If appropriate)</i>		Date:	

<p>Thank you for making a referral – please forward this to the Whānau Centred Services. Contact details can be found at www.wcsw.org.nz</p>	
Post:	P O Box 221, Putaruru, 3411
Email:	referral@wcsw.org.nz

Referrer signature:	
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