**

**Referral to services**

***Initial Contact***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | M/F | | Date: | | | |
| Email: | | | | | By phone □ email □ Mail □  Walk in □ Text □ Other □ | | | |
| Phone numbers  Cell | | | Address: | | | | | |
| Best time to call | | | Would you like a text first? | | | | | |
| Permission to leave message: Yes □ No □ | | | Permission to text: Yes □ No □ | | | | | |
| **PROGRAMME/SERVICE initially identified** | | | | | | | | |
| Central Otago Counselling |  | Individual | | Couple | |  | |  |
| Central Social Work |  |  | |  | |  | |  |
| Seasons for Growth |  | Adult | | Child | |  | |  |
| Supervision |  |  | |  | |  | |  |
| If this referral is from another professional please identify here | | | | | | | | |
| Professional name | | | Contact (phone)  Email | | | | | |
| Organisation | | | | | | | | |
| Where appropriate have you explained that we will make contact within 5 working days and that the staff member will discuss with them when they can expect to receive service? □ | | | | | | | | |
| Other: | | | | | | | | |
| Name of Staff member taking referral | | | | | | | | |
| Allocated to (Staff/programme name) | | | | | | | Date | |
|  | | | | | | | Time Taken | |

**Second Contact and Clarification of service**

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| **Date of second contact** | | | | | | **Name of Staff Member** | | | | | | |
| Date of Birth | | | | | | Gender M / F / T / or……………………….. | | | | | | |
| Ethnicity | | | | Iwi | | | | | | Secondary Iwi | | |
| Country of Origin (if appropriate) | | | | | NHI (if appropriate) | | | | | | | |
| **Presenting Issue(s)**   * Alcohol / Drugs / Other Addictions * Disability – Intellectual / Physical * Family Violence * Financial issues * Food/Housing issues * Grief and Loss | | | | | * Mental Health (Anxiety / Depression / other * Parenting * Physical Health * Relationship Conflict * Social Support needs * Statutory Requirement (MCOT/Court) * Trauma | | | | | | | |
| Referral made by client □ Other □ How did they come to us? | | | | | | | | | | | | |
| **Other Interested Parties** eg, Mental Health □ MCOT □ Education □ Legal □ Social Service □ Other □ | | | | | | | | | | | | |
| Name | | | Contact (phone/email) | | | | | Organisation | | | | Permission to Contact □ |
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| **Other relevant services involved?** | | | | | | | | | | | | |
| **Income**  Waged □ Part Benefit □ Benefit □ No income □  Weekly Household Income <$300 □ $300-$600 □ $600-$900 □ $900 - $1200 □ >$1200 □ | | | | | | | | | | | | |
| **Family/Whanau Composition**: (T=together, S= Separated, SH= Shared Care, SU= Supervised contact) | | | | | | | | | | | | |
| Name | Date of Birth | | | | | | Relationship to Client | | | | Contact (T/S/SH/SU) | |
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| Other relevant Information | | | | | | | | | | | | |
| Does the client understand the next step in the process? □  Have you explained our fee structure and the application of subsidies? □  Did you explain that the information we take is private and confidential? □ | | | | | | | | | | | | |
| **PLAN** – confirm service assigned to and next steps. | | | | | | | | | | | | |
| To be uploaded to PAUA as Referral/Enquiry | | Date: | | | | | | | Client Number: | | | |
| Time Taken (Contact): | | | | | | | Time Taken (Uploading): | | | |