****Referral/Enquiry to services**

|  |  |
| --- | --- |
| ***Initial Contact*** | **Date:** |
| Full Name Primary Client: |  Name known by:  | M/F/T/ |
| Full Name Secondary Client: | Name known by:  | M/F/T/ |
| Email: | By phone □ email □ Mail □Walk in □ Text □ Other □ |
| Phone 1 Phone 2 | 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** |
| A.B.C.  |  |  |  |  |  |
| Birth Support Group |   |  |  |  |  |
| Best Start |  |  |  |  |  |
| Central Otago Counselling |  | Individual | Couple |  |  |
| Central Social Work |  |  |  |  |  |
| Counselling  |  | Individual | Couple |  |  |
| Community Support |  | Food  | Lunch | Power fund |  |
| Game On |  |  |  |  |  |
| Kainga Ora  |   |  |  |  |  |
| Social Work  |  | Parenting | Other |  |  |
| Seasons for Growth |  | Adult | Child | Training |  |
| Supervised Contact |  |  |  |  |  |
| Supervision |  |  |  |  |  |
| Toolbox  |  | Babies and toddlers (0-4) | Primary (5-9) | Teenager (14up) | Grandparents Raising Grandchildren |
| How did they come to us? Referral made by client □ Internal □ Other □ (if made by another professional please enter below) |
| Professional name | PhoneEmail |
| Organisation |
| 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 | Date |
| Allocated to (Staff/programme name)  | Time Taken |

**Second Contact and Clarification of service**

|  |  |
| --- | --- |
| **Date of second contact** | **Name of Staff Member** |
| Date of Birth (Primary)EthnicityIwi Country of Origin (if appropriate) | Date of Birth (Secondary)EthnicityIwi Country of Origin (if appropriate) |
| NHI (if appropriate) |  |
| **Presenting Issue(s)*** Antenatal
* 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
 |
| **Other Interested Parties** eg, Mental Health □ MCOT □ Education □ Legal □ Social Service □ Other □  |
| Name | Contact (phone/email) | Organisation | Permission to Contact □ |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **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/age | Relationship to Client | Contact (T/S/SH/SU) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| 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): |