## Whānau/Family Works Intake & Referral Form FamilyWorksA1

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| **Name of Parent/Caregiver:** | | | | | | | |
| First name:Last/family name: | | | | | Gender: D.O.B:  Phone: | | |
| Street Address:Suburb: City/Town: Post Code: | | | | | Mobile:  Email:  Relationship/Role: | | |
| Ethnicity: NZ Maori ❑ NZ European❑ Pacific Island ❑ Asian ❑ Other: | | | | | | | |
| Relationship Status: Single ❑ Married / Partner ❑ Separated ❑ Divorced ❑ Widow/er ❑ Young person ❑ | | | | | | | |
| **Name of other Significant Parent/Caregiver/Partner:** | | | | | | | |
| First name:Last/family name: Address: (if different from above) | | | | | Gender: D.O.B:  Phone:  Mobile:  Email:  Relationship/Role: | | |
| Ethnicity: NZ Maori ❑ NZ European❑ Pacific Island❑ Asian ❑ Other: | | | | | | | |
| **Name of Child or Young Person if the Client:** | | | | | | | |
| First name:Last/family name: Address: (if different from above) | | | | | Gender: D.O.B:  Phone:  Mobile:  Email:  School and Year: | | |
| Ethnicity: NZ Maori ❑ NZ European❑ Pacific Island❑ Asian ❑ Other: | | | | | | | |
| **Other children in this Family:** | | | | | | | |
| First Name | Last Name | DOB | | Gender | | Ethnicity | School and Year if Applicable |
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| If this referral is from an Agency, does the client know about and agree to this referral? Yes ❑ No ❑  (If under 16 yrs do the parents/caregivers know and agree? Yes ❑ No ❑  If this referral is a parent referring - are the child/ren living with you for at least 3 – 4 days/nights per week? Yes ❑ No ❑ If no please provide details: | | | | | | | |
| **Referral Details:** | | | | | | | |
| **What are the reasons for the referral? Please give as much detail as possible**    Please Turn Over | | | | | | | |
| **What are the family goals? What do you want help with from the Service:** | | | | | | | |
| **What other Agencies/Services are involved and what are they providing?** | | | | | | | |
| **Is there a Protection Order in place?** Yes**❑** No**❑** | | | Details: | | | | |
| **Other relevant information including previous interventions, legal orders in place, parenting programmes?** | | | | | | | |
| If Oranga Tamariki are involved, please note Social Worker’s name and contact details:  Name: Phone Number: | | | | | | | |
| Medical Support Contact Details:  Doctors name: | | | | | Medical Centre Name:  Phone:  Email Address: | | |
| **Availability for appointments:** | | | | | | | |
| Are there any specific cultural, language or disability needs? | | | | | | | |
| **Referral Source**: Self ❑Family/friend ❑ Education ❑ Health ❑Mental Health❑ MVCOT❑Court ❑ Police ❑  Other: | | | | | | | |
| **Referrer Details:** | | | | | | | |
| Referrer Name: Phone: Email:  Organisation: Mobile: Fax: | | | | | | | |
| **Referral completed by:**  **Name: Signature: Date:** | | | | | | | |
| **Allocated to (Clinicians Name)** | | | | | | | |