## 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)** |