

ADULT REFERRAL FORM

Please tick if you meet the following:

1. The Parent/Caregiver is aware and agrees to this referral being made to Parentline? ☐

Please tick as many as you need to that are relevant:

- | | |
|--|---|
| <p>2. Have you experienced Family Violence:</p> <p>Sexual abuse <input type="checkbox"/></p> <p>Physical abuse <input type="checkbox"/></p> <p>Emotional abuse <input type="checkbox"/></p> <p>Neglect <input type="checkbox"/></p> <p>Abuse of your pets/animals <input type="checkbox"/></p> <p>Dowry Abuse <input type="checkbox"/></p> <p>3. Have you experienced:</p> <p>Trauma <input type="checkbox"/></p> <p>Bullying <input type="checkbox"/></p> | <p>4. Parent/Caregiver wishes to attend:</p> <p>Incredible Years Parenting Programme <input type="checkbox"/></p> <p>Manaakitia Mai <input type="checkbox"/></p> <p>Keeping Ourselves Safe <input type="checkbox"/></p> <p>Social Work Supports <input type="checkbox"/></p> <p>Family Counselling <input type="checkbox"/></p> |
|--|---|

If the above entry criterion are met, please complete all sections of this e-referral form and send it to the above email address. Your referral will be formally acknowledged. Thank you.

CLIENT DETAILS:

REFERRAL DATE:

 / / 201

| | | | |
|--|--|---|-----------------|
| Surname: | | Given Names: | |
| Also known as: | | Address: | |
| Suburb: | | City/Town: | Postcode: |
| D.O.B. | Gender: F / M | Main phone contact: | |
| Email address: | | Alternate / mobile phone: | |
| Ethnicity: | | Refugee: Yes/No | Migrant: Yes/No |
| Iwi/ Hapu (if Maori): | | Languages / Can client speak English? | |
| Is there family violence? | | Currently / Historically | |
| Do you have a Protection Order | | Yes / No | |
| Protection Order No: | | | |
| Date/Place of Issue: | | (copy for our files please) | |
| 3 rd Party service providers (tick the following services that are/have been involved): | | | |
| GP/ Doctor (who?) <input type="checkbox"/> | Police/ ISR (who?) <input type="checkbox"/> | Corrections Services <input type="checkbox"/> | |
| Imms up to Date? <input type="checkbox"/> | WSW <input type="checkbox"/> | Counselling services <input type="checkbox"/> | |
| | | Disability services <input type="checkbox"/> | |
| NGO services (who?) <input type="checkbox"/> | MVCOT or/ Childrens Team? <input type="checkbox"/> | ICAMHS <input type="checkbox"/> | |
| | | Legal services <input type="checkbox"/> | |
| | Disability services <input type="checkbox"/> | Work and Income <input type="checkbox"/> | |

The information contained herein is private, privileged and confidential. It cannot be released except by the CEO of Parentline, upon receipt of written consent by the client if appropriate or their guardian. Not to be duplicated or transmitted.

List the people living in the household:

| Full Name | Relationship to Client | Date of Birth |
|-----------|------------------------|---------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Significant family members living Outside the Home

| Name | Relationship to Client | Date of Birth |
|------|------------------------|---------------|
| | | |
| | | |
| | | |

Relationship status ☐ Married ☐ Divorced ☐ Separated ☐ De Facto ☐ Same Sex

SECONDARY CONTACT PERSON DETAILS

| | | |
|-------------------------|--------------|--------------------|
| Relationship to client: | Guardian: | Preferred contact: |
| Surname: | Given names: | |
| Email: | Phone: | |
| | Mobile: | |
| Address: | Suburb: | Post Code: |

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HOW WE CAN WORK WITH YOU?:

COMMUNICATION PLAN

Parentline Staff will need to communicate with you and plan for sessions with you. Please let us know times to contact you and how/when you would prefer to be contacted:

| | | | |
|---|--------------------------------|-------------------------------|--------------------------------|
| I agree to be contacted by: | Phone <input type="checkbox"/> | Text <input type="checkbox"/> | Email <input type="checkbox"/> |
| PHONE: | | | |
| EMAIL: | | | |
| The best times to contact me: | Mon | | |
| | Tues | | |
| | Wed | | |
| | Thurs | | |
| | Fri | | |
| I am happy to be contacted at my place of work if you are unable to contact me any other way. | Yes/ No Circle One | Work phone: | |
| Hours of Work | | | |

REFERRAL DETAILS (IF OTHER THAN SELF-REFERRAL)

| | | | |
|--|----------------|------------|--|
| Referral source: | Full Name: | | |
| Address: | Suburb: | Post Code: | |
| Mode: | Phone contact: | | |
| Referrer Role: | Email address: | | |
| Referrer has discussed referral with <input type="checkbox"/> client <input type="checkbox"/> client/guardian <input type="checkbox"/> next of kin <input type="checkbox"/> don't know | | | |

REFERRER CONCERNS:

Comments please

| | | |
|--|--------------------------|-------|
| How long has this problem been a concern? | <input type="checkbox"/> | _____ |
| When was the difficulty first noticed? | <input type="checkbox"/> | _____ |
| Has the difficulty been evaluated or treated before? | <input type="checkbox"/> | _____ |
| Is the difficulty a medical illness? | <input type="checkbox"/> | _____ |
| Does the client have a suspected mental health diagnosis? | <input type="checkbox"/> | _____ |
| Does the client have a confirmed mental health diagnosis? | <input type="checkbox"/> | _____ |
| Is the difficulty primarily related to situational stress? | <input type="checkbox"/> | _____ |
| Is the client on any medication? | <input type="checkbox"/> | _____ |
| Is the difficulty related to family issues? | <input type="checkbox"/> | _____ |
| Is the difficulty related to family harm? | <input type="checkbox"/> | _____ |

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REFERRER REPORTS:

(PLEASE ATTACH A COPY WHERE POSSIBLE)

Assessments Completed – List

Other Reports e.g ROC's, FGC's, CAN

FAMILY PROTECTIVE FACTORS

- | | |
|--|--|
| <input type="checkbox"/> Good family support network | <input type="checkbox"/> Access to good adult role models |
| <input type="checkbox"/> Good social support network | <input type="checkbox"/> Personal insight into difficulties |
| <input type="checkbox"/> Accesses community services and resources | <input type="checkbox"/> Motivated to change |
| <input type="checkbox"/> Stable housing | <input type="checkbox"/> Secure family history |
| <input type="checkbox"/> Stable employment | <input type="checkbox"/> Working with Childrens Team Lead Professional |
| | <input type="checkbox"/> Working with Whanau Support Worker |

FAMILY RISK FACTORS

- | | |
|--|--|
| <input type="checkbox"/> Adult relationship difficulties | <input type="checkbox"/> Suicidal / self harming behaviours |
| <input type="checkbox"/> No family support | <input type="checkbox"/> Sexual abuse history (parent/family member) |
| <input type="checkbox"/> Current legal concerns | <input type="checkbox"/> Socio-economic difficulties |
| <input type="checkbox"/> Domestic / Family Violence concerns | <input type="checkbox"/> Accommodation issues |
| <input type="checkbox"/> Drug and alcohol concerns | <input type="checkbox"/> Learning / intellectual difficulties |
| <input type="checkbox"/> Grief and loss concerns | <input type="checkbox"/> Employment / income concerns |
| <input type="checkbox"/> Social isolation / alienation | <input type="checkbox"/> Family member in detention |
| <input type="checkbox"/> Personality concerns | <input type="checkbox"/> Family member has a disability |
| <input type="checkbox"/> Mental Health concerns | <input type="checkbox"/> General parenting concerns |

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Parentline
safe family safe child
maru i te whānau maru i te tamariki

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P O Box 11-077 HAMILTON 3251
Telephone 64 7 839-4536
Fax: 64 7 839-4515
E-mail intake@parentline.org.nz

ANYTHING ELSE YOU WOULD LIKE US TO KNOW:

The information contained herein is private, privileged and confidential. It cannot be released except by the service manager of the service from which the information originates, upon receipt of written consent by the client if appropriate or their guardian. Not to be duplicated or transmitted.