

REQUEST FOR SERVICE From Agencies

Client Details			
First Name	Middle Name	Surname/Family Name	Date of Birth
Ethnicity/lwi:		Country of Birth:	Gender: M <input type="checkbox"/> F <input type="checkbox"/> Other _____
First Name	Middle Name	Surname/Family Name	Date of Birth
Ethnicity/lwi:		Country of Birth:	Gender: M <input type="checkbox"/> F <input type="checkbox"/> Other _____
School attending if applicable:			

Family/Whanau Details					
Name	Date of Birth	Gender	Ethnicity/lwi	Relationship to client	
		M <input type="checkbox"/> F <input type="checkbox"/> O <input type="checkbox"/>			
		M <input type="checkbox"/> F <input type="checkbox"/> O <input type="checkbox"/>			
		M <input type="checkbox"/> F <input type="checkbox"/> O <input type="checkbox"/>			
		M <input type="checkbox"/> F <input type="checkbox"/> O <input type="checkbox"/>			

Contact Information/Details:					
Address				Postal Code	
Landline Phone No.	Mobile	Mobile	Email		
Clients preferred way of contact					
Mobile Yes <input type="checkbox"/> No <input type="checkbox"/>	Landline Yes <input type="checkbox"/> No <input type="checkbox"/>	Letter Yes <input type="checkbox"/> No <input type="checkbox"/>	Text message Yes <input type="checkbox"/> No <input type="checkbox"/>	Voice message Yes <input type="checkbox"/> No <input type="checkbox"/>	Email Yes <input type="checkbox"/> No <input type="checkbox"/>
What are the best times to contact the client?			What times is the client available for sessions/visits		
			Day <input type="checkbox"/> morning <input type="checkbox"/> afternoon <input type="checkbox"/> evening <input type="checkbox"/>		

Reason for Referral/Background information:
.....
See over page for more space if required

Family Works Service Required
Service/Programme Referred for: _____
Is the client currently working with Family Works? Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>
Has client used our services before? Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/>

Additional Information

Please attach a copy of any relevant assessment, reports or any additional information to support this referral

Any other additional information that you would like to add.

Other Agencies or Professionals Involved

Agency	Name	Contact Phone No.	involvement

Risks/Safety

Any concerns regarding the safety of the client or client's family e.g. child/young person?

Yes No
Not known **Risks/Safety**

Family violence or partner violence issues.

Current
Yes No
Not known **Past**
Yes No
Not known

Concerns re mental health (Issues of risk or self-harm)

Yes No
Not known Protection Orders
Trespass Notice/Order
Police Safety Order
Restraining OrderYes No
Yes No
Yes No
Yes No

Alcohol/drug issues

Yes No
Not known

Any known risks affecting a staff member working with this client/family in their home?

Yes No
Not known

Oranga Tamariki Involvement

Yes No
Not known

If yes to Oranga Tamariki involvement what is the current status that the children have.

Status/Orders

Additional space if required.

Agency Referrer InformationBefore making this request for service it is important that the individual/family has been consulted and has given their consent. Please indicate that consent has been obtained: Yes

Name:

Organisation:

Phone No:

Mobile No:

Email :

Fax No:

As the referrer do you require contacting before we phone the client?

Yes No

Date: