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Fulfilled Lives, Connected Communities

PĀPĀMOA FAMILY SERVICES REFERRAL FORM

(To be completed by ACW staff, self-referrer, or referring agencies)

PLEASE NOTE – We are not a crisis response service. If there is immediate or significant risk to safety of self or others contact Mental Health Crisis Line 0800 800 508 OR the NZ Police OR Oranga Tamariki 0508 326 459.

Recorded by:				Date:	
What services are requested?	☐	Social work	☐	Financial mentoring	
	☐	Counselling	☐	Youth work	
	☐	Programmes	☐	Growing Through Grief	
	☐	Other: (*please specify*):			

SECTION 1: CLIENT DETAILS					
Client's name:	**Gender:**			**Date of birth:**	
	☐M	☐F	☐Non-Binary	**Age:**	
Client's Address:					
Client's email:					
Client's home phone:				Client's mobile phone:	
Permission to leave voice mail:				☐Yes	☐No
Permission to send TXT message:				☐Yes	☐No
Do you have children in your care aged 0-17 years?				☐Yes	☐No
Client's ethnicity: **For statistical purposes always use Māori or Pacific as primary ethnicity if more than one ethnicity.*	☐ NZ European/ Pākehā			☐ Asian	☐ Middle Eastern, African or Latin American
	☐ Māori			☐ Pacific peoples	☐ Other/prefer not to answer
If the client is a child/minor, please complete the following:					
Relationship to client	☐ Mother			☐ Father	☐ Other
Caregiver's name:				Date of birth:	
Caregiver's address:					
Caregiver's email:					
Client's home phone:				Client's mobile phone:	
Best time to contact				☐ AM	☐ PM

SECTION 2: FAMILY AND SIGNIFICANT OTHERS							
Name:	Relationship	DOB:	Gender:			School/ECE:	Age
			☐M	☐F	☐NB		
			☐M	☐F	☐NB		
			☐M	☐F	☐NB		
			☐M	☐F	☐NB		
			☐M	☐F	☐NB		
			☐M	☐F	☐NB		

SECTION 3: BRIEF DESCRIPTION OF MAIN REASON FOR REFERRAL

SECTION 4: INITIAL ASSESSMENT OF RISK	
URGENCY OF SITUATION: (in client/referrer's view)	☐ Urgent
	☐ High priority
	☐ Medium priority
	☐ Low priority

SECTION 5: ADDITIONAL INFORMATION GATHERED FOR REFERRAL
Does referred person have any special needs, disabilities, medical alerts, allergies, or other issues we need to be aware of?
With which other agencies is the referred person currently working?

SECTION 6: REFERRER DETAILS – *if self-referred this is not necessary*					
Does the client give consent for this referral?		☐Yes	☐No		
Referral organisation:		Contact phone:		Mobile:	
Referrer's name:		Address:			
Relationship to client:		Email:			

SECTION 7: REFERRAL SIGN OFF			
Client /Referrer signature:		Date:	

Please sent to admin.pfs@acw.org.nz

OFFICE USE ONLY	☐ Referral accepted:	☐ Referral declined:
	Reason for declining:	
	Agency to refer to:	