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| **Confidential** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Before making an interagency referral it is important that the individual/family/whānau being referred has been consulted and has given their consent.* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral discussed with individual/family/whānau, and consent obtained:** | | | | | | | | | | | | | | | | | | | | | | | | | Yes / No | |
| **Referrer Details** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date:** |  | | | | | | | | | | | | | **Agency:** | | | |  | | | | | | | | |
| **Name:** |  | | | | | | | | | | | | | **Phone:** | | | |  | | | | | | | | |
| **Email:** |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client Details** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **First Name:** | |  | | | | | | | | | | **Family Name:** | | | | | | |  | | | | | | | |
| **Known as:** | |  | | | | | | | | | | | | | | **Date of Birth:** | | | | |  | | | | | |
| **Gender:** | | | | Male | | | | Female | | | | Other (specify) | | | | | | | | | | | | | | |
| **Ethnicity:** | | | | Māori | | | | NZ European | | | | Pacific Island | | | | | | | Asian | | | European | | | | Other |
| **If ‘Māori’ please specify Tribe/Iwi:** | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| **If ‘Pacific,’ ‘Asian,’ ‘European,’ or ‘Other’ please specify:** | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| **Contact Details** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Street Address:** | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Suburb:** | | | | |  | | | | | | | | | | **City:** | |  | | | | | | | | | |
| **Home Phone:** | | | | |  | | | | | | | | | | **Mobile Phone:** | | | | |  | | | | | | |
| **Email:** | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Parent/Caregiver Information**  *(If applicable)* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Parent one:** | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Address:**  *(If different to above)* | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Contact Details:** | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Parent two:** | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Address:**  *(If different to above)* | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Contact Details:** | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Caregiver/Other:** | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Address and Contact Details:** | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Family/Whānau Details** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | | | | | **Relationship:** | | | | | | **Address:** | | | | | | | | | | | **DoB:** | | |
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| **Other Agencies or Professionals Involved** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Agency:** | | | | | | **Name:** | | | | | | | | | | | | **Contact:** | | | | | | | | |
| School / College | | | | | |  | | | | | | | | | | | |  | | | | | | | | |
| Doctor | | | | | |  | | | | | | | | | | | |  | | | | | | | | |
| Other | | | | | |  | | | | | | | | | | | |  | | | | | | | | |
| **Past History with Presbyterian Support Central:** | | | | | | | | | | | | | | | | | |  | | | | | | | | |
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| **Service Requested:**  *(this can be adjusted as relevant to each service/centre, for example individual, couple, family, or programme).* | | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| **Brief History/Background and Reason for Referral:** | | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| **Other Information** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please attach any relevant MVCOT Assessment Current Summary (Tui Tuia) or FGC Report/Plan plus any additional relevant reports etc. required to deliver this intervention. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Needs:** | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Strengths:** | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **What do you wish this service to achieve?** | | | | | | | | | | | | | |  | | | | | | | | | | | | |
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| **Risks and Hazards** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please state any concerns regarding the safety of the client at work, at home, or anyone else’s (including children/family): | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| If MVCOT or Children’s Team are involved what stage are they at in the their assessment process: | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| State any mental health concerns (including any risk issues or history of self harm): | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| State any significant alcohol/drug issues: | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| State any current or historic concerns about relationship or family violence: | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Is there a Protection Order in place for this client or a member of the client’s family? If so, name the respondent and/or name the protected person: | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Is there a Police Safety Order in place for this client? | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Detail any known hazards affecting a staff member working with this client or family alone, or visiting the client/family in their home (e.g. violence, dogs, gang issues): | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Client and/or Family Agreement to Referral** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I/We give informed consent to a referral to Family Works  I/We agree for Family Works to be invited to the FGC (if appropriate)  I/We agree for information about myself and family as above to be shared with Family works as part of this referral.  I/We agree for the following reports to be shared with Family Works to assist them in delivering a service. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature of Client/s** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client Signature:** | | | | | | | | |  | | | | | | | | | | **Date:** | | | |  | | | |
| **Parent/Caregiver Signature:**  *(If appropriate)* | | | | | | | | |  | | | | | | | | | | **Date:** | | | |  | | | |
| Thank you for making a referral – please forward this to the Family Works Centre. Contact details can be found on [www.familyworkscentral.org.nz](http://www.familyworkscentral.org.nz) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Post:** |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Email:** |  | | | | | | | | | | | | | | | | | | | | | | | | | |