DATE:

REFERRAL / INTAKE SHEET

REFERRAL SOURCE: REFERRER'S PHONE:

DUTY WORKER: ALLOCATED TO:

CLIENT / PARENT / CAREGIVER: DOB SEX ETHNICITY IWI

ADDRESS:

PHONE: (MOBILE) (WORK) (HOME)

EMAIL:

PREFERRED CONTACT

TXT: EMAIL: MOBILE: HOME: VOICEMAIL:

DEPENDENT CHILDREN DOB SEX ETHNICITY IWI

FAMILY COMPOSITION (PLEASE TICK)

Single Parent Two Parent (birth) Two Parent (step) Individual Couple Other

Current or potential risk to the child / adult / self-safety?

COMMENTS:

URGENCY / AVAILABILITY:

ISSUES

Child's Behaviour or Needs
Parenting Skills
Relationship Problems
Effects of Addictions
Effects of Violence or Abuse
Grief
Mental Health Issues

SERVICE REQUESTED

Couns. Individual
Couns. Couple
Couns. Family

PSYCHOLOGY

Child and Family
Learning Assessment
Social Work
Community Connector

Are you on a waiting list elsewhere? (please tick)

Where did you hear about our services?

Family / Friend

Health Care Provider

Church

Oranga Tamariki

School

Other CSS Programme

Other Agency

Are you a previous client of CSS? (please tick)

PREVIOUS REASON / ISSUE:

WHEN:

WITH WHOM:

BRIEF SUMMARY OF REASON FOR REFERRAL:

CSS staff use this information to respond to your request for a referral and manage the process thereafter.

We will not disclose your information to third parties unless we have your consent, or if we are required to by law.

We take all reasonable precautions to keep your information safe and secure.

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