

DATE:

REFERRAL / INTAKE SHEET

REFERRAL SOURCE:

REFERRER'S PHONE:

DUTY WORKER:

ALLOCATED TO:

CLIENT / PARENT / CAREGIVER:

AGE

SEX

ETHNICITY

IWI

PHONE: (MOBILE)

(WORK)

(HOME)

EMAIL:

PREFERRED CONTACT

Yes Leave a message

Yes leave message with another person

Yes I check voicemail

TXT:

EMAIL:

MOBILE:

yes / no

yes / no

yes / no

HOME:

yes / no

yes / no

yes / no

CHILDREN

AGE

SEX

ETHNICITY

IWI

FAMILY COMPOSITION (PLEASE TICK)

Sole Parent - Female

Sole Parent - Male

Two Parent (birth)

Two Parent (step)

Individual

Couple

Other

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

COMMENTS:

URGENCY / AVAILABILITY:

SERVICE REQUEST (PLEASE SELECT FROM DROPDOWN)

None:

MSD 1:

MSD 2:

Psychology



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

Where did you hear about our services?

Are you using this service because it is a catholic agency?

Family / Friend

Yes

No

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 REFERRALL:

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.

catholicsocialservices.nz



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