

DATE:

REFERRAL / INTAKE SHEET

REFERRAL SOURCE: REFERRER'S PHONE

DUTY WORKER: ALLOCATED TO:

CLIENT / PARENT / CAREGIVER:	AGE	SEX	ETHNICITY	IWI
.....

ADDRESS:
.....
.....

PHONE: (MOBILE) (WORK) (HOME)

EMAIL:

PREFERRED CONTACT	Yes Leave a message	Yes leave message with another person	Yes I check voicemail
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TXT:

EMAIL:

MOBILE:	<input type="checkbox"/>	yes / no	yes / no	yes / no
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HOME:	<input type="checkbox"/>	yes / no	yes / no	yes / no
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CHILDREN	AGE	SEX	ETHNICITY	IWI
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FAMILY COMPOSITION (PLEASE CIRCLE)

Sole Parent - Female	Sole Parent - Male	Two Parent (birth)	Two Parent (step)	Individual	Couple	Other
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Current or potential risk to the child / adult / self-safety?

COMMENTS:
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URGENCY / AVAILABILITY:

SERVICE REQUEST (PLEASE CIRCLE)

None: Family / Individual / Couple	MSD 1: Couns. Family / Couns. Individual / Couns. Couple
MSD 2: Social Work / Parenting / Group Programme	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:

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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.

