

Client Referral Form

Date in:	Date referred:	To:	Client no:
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PERSONAL DETAILS	
NAME:	DOB:
ADDRESS:	
HOME PHONE:	MOBILE:
ETHNICITY:	GENDER:
IWI:	
COUNTRY OF BIRTH:	
EMAIL ADDRESS:	
ALTERNATIVE CONTACT NAME:	PHONE:

Immediate Service	
Are you having thoughts about dying or feel at risk of self-harm or suicide?	

Social services	
Family harm	
Concerns and issues for individuals, whaanau/families	
Oho Workshops – 4wks for women affected by harm, mental health and or addictions	

Counselling	
I would like to resolve issues and reach decisions. Work through loss, resolve and put to rest concerns, past trauma, anxiety, depression and anger. Add meaning to life.	
My child/ren have witnessed violence (5-18yrs)	

Transport	
Transport to and from medical appointments (<i>this is a volunteer service and 48 hrs notice is required</i>)	

Parenting Programmes	
Antenatal Education Free 4 week antenatal course for expecting parents	
Incredible Years 1 – 3 years for parents/caregivers with children 1 – 3 years	
Incredible Years 3 – 8 years for parents/caregivers with children 3 – 8 years	
Parenting Toolbox for Teens 6 week course for parents of teenagers 12 – 18 years	

Financial Mentoring	
<i>Please circle if applicable</i>	
Eviction Disconnection Debts Re-possession Rent Future Planning On-going budgeting support	
Energy Mates	
Understanding your power bill Discuss options to minimise your power usage	

Please provide any details that might help the team to further support you and or your whaanau:

Children Details		
Child Name	DOB	Gender

Referrer details	
Have you (referrer) obtained consent from the whaanau to make this referral	Yes / No
Referrer name	
Referrer organisation	
Phone	
Email	

Informed Consent:

I understand this referral will go to the Franklin Family Support Services team so they can work together to provide the best support available.

Confidentiality is maintained within the team.

PRINT NAME:

SIGNED: