Referral Information

Please return to: PO Box 2462, Dunedin 9044 or [manager@mtcargilltrust.org.nz](mailto:manager@mtcargilltrust.org.nz)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name |  | | | | |
|  |  | | | | |
| Date of Birth: | Click or tap to enter a date. | Age: | |  | |
|  |  | | | | |
| Date of Referral: |  | | | | |
|  |  | | | | |
| Referred By: |  | | | | |
|  |  | | | | |
| Current Address: |  | | | | |
|  |  | | | | |
| Ethnicity: |  | | | | |
|  |  | | | | |
| Iwi (*if applicable*): |  | | | | |
|  |  | | | | |
| Languages spoken at home: |  | | | | |
|  |  | | | | |
| Community Services Card: |  | | Expiry Date: | | Click or tap to enter a date. |
|  |  | | | | |
| If Yes, CSC Number: |  | | | | |
|  |  | | | | |
| NHI Number: |  | | | | |

## Parent Information

|  |  |  |
| --- | --- | --- |
| Parent 1: |  | |
|  |  | |
| Address: |  | |
|  |  | |
| Telephone | Home: |  |
|  | Work: |  |
|  | Cellphone: |  |
|  |  | |
| **Parent 2:** |  | |
|  |  | |
| Address: |  | |
|  |  | |
| Telephone | Home: |  |
|  | Work: |  |
|  | Cellphone: |  |

**Names of Guardian/s or Foster Parent/s:**

|  |  |  |
| --- | --- | --- |
| Name/s: |  | |
|  |  | |
| Address: |  | |
|  |  | |
| Telephone | Home: |  |
|  | Work: |  |
|  | Cellphone: |  |

**Referral Agent:**

|  |  |
| --- | --- |
| Name: |  |
|  |  |
| Relationship: |  |
|  |  |
| Address: |  |
|  |  |
| Telephone: |  |

**Referral Summary (*Significant Points*):**

|  |
| --- |
|  |

**Valid Care or Protection Orders:**

|  |
| --- |
|  |

**Other Services involved with this whanau/tamariki/rangitahi:**

|  |
| --- |
| e.g. Oranga Tamariki, ACC, YSS, CAFMS, Your Way|Kia Roha (NASC). (Please include all relevant reports) |

**Other Support Systems already in place:**

|  |  |
| --- | --- |
| Needs assessment completed? (If applicable) | Choose an item. |
| Date Completed: | Click or tap to enter a date. |
| Copy attached: | Choose an item. |

|  |  |
| --- | --- |
| Is there a Residential Support Subsidy in place? | Choose an item. |
| Level: |  |
| Respite Care – Care Support Days available?  (if applicable) | Choose an item. |
| Specialists involved: |  |

**Specialists involved:**

|  |
| --- |
|  |

**Current Living Placement:**

|  |
| --- |
|  |

**Family / Whanau Relationship:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship | Date of Birth | Gender |
|  |  | Click or tap to enter a date. |  |
|  |  | Click or tap to enter a date. |  |
|  |  | Click or tap to enter a date. |  |
|  |  | Click or tap to enter a date. |  |
|  |  | Click or tap to enter a date. |  |
|  |  | Click or tap to enter a date. |  |

**Home Environment:**

**Tamariki/Rangatahi’s relationship with:**

|  |  |
| --- | --- |
| Whanau:  (Parent’s/Caregivers) |  |
| Siblings: |  |
| Other Adults: |  |
| Peers: |  |
| Authority Figures: |  |

**Developmental History:**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Is there any forensic history? |  |
| Psychometric testing: |  |
| IQ range |  |
| Test Used |  |
| Comment: |  |

**Behaviours of Concern:**

|  |
| --- |
| Home Context: |
| School context: |

**Interventions:**

|  |
| --- |
| What interventions have been tried for these behaviours? |
| Outcomes of interventions: |
| Has the application been discussed with the tamariki/rangatahi?  (if No, please outline reasons. If Yes, please describe their reaction/attitude) |

**History:**

|  |
| --- |
| Has the tamariki/rangatahi displayed any sexualized behaviours? |
| If yes, please detail the behaviours:  Specific nature – contact with adults/peers/younger children |

**Is there any history of the following?**   
*(If yes – please specify in detail and send copies of reports/assessments)*

|  |  |
| --- | --- |
| Violent behaviour: |  |
| Arson/Fire lighting: |  |
| School aggression: |  |
| Home aggression: |  |
| Property damage: |  |
| Use of weapons: |  |
| Police/Youth Justice intervention: |  |
| Alcohol/Drug/Solvent abuse: |  |
| Self-harm or suicidal ideation: |  |

**Healthcare provider’s information**

|  |  |
| --- | --- |
| Doctor / GP: |  |
| Address: |  |
| Phone number: |  |

|  |  |
| --- | --- |
| Dentist |  |
| Address: |  |
| Phone number: |  |

|  |  |
| --- | --- |
| Specialist: |  |
| Address: |  |
| Phone number: |  |

|  |  |
| --- | --- |
| Specialist: |  |
| Address: |  |
| Phone number: |  |

|  |  |
| --- | --- |
| Specialist: |  |
| Address: |  |
| Phone number: |  |

|  |  |
| --- | --- |
| Other: |  |
| Address: |  |
| Phone number: |  |

## Health History for Click or tap here to enter name.

*(This page must be completed by a GP or Specialist)*

|  |  |
| --- | --- |
| Diagnoses: |  |
| Current medications: |  |
| Allergies: |  |
| Personal History: |  |
| Immunisations: |  |
| General Health: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Doctor:** |  | | |
| **Signature:** |  | **Date:** |  |