Referral Information

Please return to: PO Box 2462, Dunedin 9044 or 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:** |  |