# WHĀNAU REFERRAL /INTAKE FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **PERSONAL DETAILS REFERRAL DATE:** | | | | | | | | | | | | |
| **First Name** | | |  | | |  | | **Gender** | | | M F | |
| **Middle Initial** | | |  | | |  | |  | | |  | |
| **Last Name** | | |  | | |  | | **Date of Birth** | | |  | |
|  | | |  | | |  | |  | | |  | |
|  | | | | | | | | | | | | |
| **ADDRESS DETAILS** | | | | | | | | | | | | |
| **Home Address** | | |  | | |  | | **Residence** | | | | * Private Household * Group Home * Residential Facility * Prison * Shelter * Other |
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|  | | |
|  | | |
|  | | |
| **Home Phone** | | |  | | |  | | **Work Phone** | | | |  |
| **Mobile Phone** | | |  | | |  | | **(This number will be added to your file as contactable)** | | | | |
|  | | | | | | | **Email** | | | | |  |
|  | | | | | | | **(This will be added to your file as contactable)** | | | | | |
| **WHAKAPAPA** | | | | | | | | | **DOCTOR** | | | |
| **Ethnicity** |  | | | | |  | | **Doctor** | |  | | |
| **Iwi** |  | | | | |  | | **Clinic** | |  | | |
| **Hapu** |  | | | | |  | | **Phone** | |  | | |
|  | | | | | | | | | | | | |
| **ADDITIONAL DETAILS FOR TAMARIKI/RANGATAHI** | | | | | | | | | | | | |
| **Contact Details for** | | | * Mother 🞎 Father 🞎 Guardian | | | | | | | | | |
| **Name**  **Address** |  | | | | |  | | **Home Phone** | | |  | |
|  | | | | |  | | **Mobile Phone** | | |  | |
|  | | | | |  | | **Work Phone** | | |  | |
|  | | | | | | | | | | | | |
| **EMERGENCY CONTACT** | | | | | | | | | | | | |
| **Name** | |  | | | |  | | **Relationship** | | |  | |
| **Home Phone** | |  | | | |  | | **Mobile Number** | | |  | |
| **Comments** | |  | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **REFERRAL DETAILS (Complete if referred from an agency)** | | | | | | | | | | | | |
| **Referral Date** | | |  | | |  | | **Work Phone** | | |  | |
| **Referral Source** | | | 🞎 Agency 🞎 Self 🞎 Whanau | | |  | | **Mobile Phone** | | |  | |
| **Contact Person** | | |  | | |  | | **Email Address** | | |  | |
| **Primary Reason for Referral** | | |  | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
| **Are there children currently in your care?** | | | * **Unknown** * **Yes\*** * **No** | | **Are you currently involved with other agencies? If yes, please indicate.**   * **Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * **No** | | | | | | | |
| **How did you hear about us?** | | | |  | | | | | | | | |
| **Referral received by:** | | | |  | | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REASON FOR REFERRAL** | | | | | | | | |
| **(What does the client hope to gain from Āwhina Whānau Services?)** | | | | | | | | |
|  | | | | | | | | |
| **PRESENT CIRCUMSTANCES – \*include any children *in your care*, name and date of birth** | | | | | | | | |
| **(Living circumstances, employment, schooling, support networks etc)** | | | | | | | | |
|  | | | | | | | | |
| **Risk Assessment (Kessler) In the last two weeks, how often did you feel? (please circle)** | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **RATING SCALE** | **NONE** | **LITTLE** | **SOME** | **MOST** | **ALL** | | So sad nothing could cheer you up? | 0 | 1 | 2 | 3 | 4 | | Worried or Frightened? | 0 | 1 | 2 | 3 | 4 | | Restless or Stressed? | 0 | 1 | 2 | 3 | 4 | | Hopeless? | 0 | 1 | 2 | 3 | 4 | | That everything was an effort? | 0 | 1 | 2 | 3 | 4 | | Worthless? | 0 | 1 | 2 | 3 | 4 | | | | | | | | | |
| **Assessment (Please tick if applicable )** | | | | | | | | |
| * Kessler 20+ * High anxiety * High fear state * Financial issues * Accommodation * Depression * Clinical condition (state)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | * Suicidal ideation * Intent to harm: High / Low / Plan (circle) * Appetite * Self-harm * Low mental health * Alcohol issues * Drug issue * Emotion regulation issues | * Relationship issues * Safety issues * DV/FV * Sexual abuse * Psychological/emotional abuse * Sleep disturbances * Mood swings (highs/lows) * Grief/loss | | | | * Historical trauma * Lack of support * Social stressors * Esteem issues * Environment issues * Health issues * Physical issues * OTHER (state)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **OFFICE USE ONLY** | | | | | | | | |
| **Score \_\_\_\_\_\_\_\_\_\_\_\_\_** | **Priority:**  Low Med High | | |  | **Referral Date:** |  | |  |
| **Contract (one only)**   * **MSD** * **PHO** * **OTHER**   **\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_** | * Counselling * Te Rito o te Whānau * Sexual Harm Crisis Support – Adult * Sexual Harm Crisis Support – Child/Youth * Youth Development Programme * Youth Justice * Mental Health Counselling * Turangawaewae * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | **Entered into Exess:** |  | |
| **Entered into Book:** |  | |
| **Receipt of Referral sent:** |  | |
| **Allocation Date:** |  | |
| **Allocated To:** |  | |
|  |  | |