# 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 Reasonfor 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:** |  |

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| **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 |

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| **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:** |  |
|  |  |