WHĀNAU REFERRAL/INTAKE FORM

ĀWHINA WHĀNAU SERVICES
INSPIRING CHANGE INSPIRING WHĀNAU

PERSONAL DETAILS

First Name _____
Middle Initial _____
Last Name _____

REFERRAL DATE:

Gender M F Gender Diverse
Date of Birth _____

ADDRESS DETAILS

Home Address _____
_____
_____
_____

Home Phone _____
Mobile Phone _____
Work Phone _____
(This number will be added to your file as contactable)

Email _____ **(This will be added to your file as contactable)**

WHAKAPAPA

Ethnicity _____
Iwi _____
Hapu _____

DOCTOR

Doctor _____
Clinic _____
Phone _____

ADDITIONAL DETAILS FOR TAMARIKI/RANGATAHI

Contact Details for ☐ Mother ☐ Father ☐ Guardian
Name _____
Address _____
_____

Home Phone _____
Mobile Phone _____
Work Phone _____

EMERGENCY CONTACT

Name _____
Home Phone _____
Comments _____

Relationship _____
Mobile Phone _____

REFERRAL DETAILS (complete if referred from an agency)

Referral Date _____
Referral Source ☐ Agency ☐ Self ☐ Whanau
Contact Person _____

Work Phone _____
Mobile Phone _____
Email _____

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 _____

Send completed Referral Form to Āwhina Whānau Services - fax (06) 878-4185 or email to office@aws.org.nz

REASON FOR REFERRAL

(Please state the reason(s) you are wanting to come to Āwhina Whānau Services and what you hope to gain)

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)

- ☐ High anxiety
- ☐ High fear state
- ☐ Financial issues
- ☐ Accommodation
- ☐ Depression
- ☐ Grief/loss
- ☐ Clinical condition (please state)

_____

- ☐ Low appetite
- ☐ Suicidal ideation
- ☐ Intent to harm: High / Low / Plan (circle)
- ☐ Self-harm
- ☐ Low mental health
- ☐ Alcohol issues
- ☐ Drug issues
- ☐ Emotion regulation issues

- ☐ Relationship issues
- ☐ Safety issues
- ☐ Domestic violence
- ☐ Family violence
- ☐ Sexual abuse/harm
- ☐ Psychological/emotional abuse
- ☐ Historical trauma
- ☐ Sleep disturbances
- ☐ Mood swings (highs/lows)

- ☐ Lack of support
- ☐ Social stressors
- ☐ Esteem issues
- ☐ Environment issues
- ☐ Health issues
- ☐ Physical issues
- ☐ OTHER (please state)

_____

_____

OFFICE USE ONLY

Score _____ **Priority:** Low Med High

- ☐ SHCSS
- ☐ SHCS CY
- ☐ FVRESP
- ☐ CS FW
- ☐ YJ FW
- ☐ YDP
- ☐ TAT
- ☐ LC
- ☐ AWS
- ☐ OTHER

- ☐ Counselling &/or Social Work
- ☐ Piringa Whānau
- ☐ Police Diversion
- ☐ Tamariki Kaha Programme
- ☐ Te Ara Totika – Rangatahi Resilience Programme
- ☐ Te Rito o te Whānau
- ☐ Youth Development Programme
- ☐ Youth Justice
- ☐ Other (please note) _____

	DATE	INITIAL
Referral Received:		
Entered into Exess:		
Allocated to Waharoa:		
Waharoa Completed:		
Allocated by :		
Allocated to: (name):		

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