# ReachOut Referral Form

**Referrer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Organisation** |  | **Date of Referral** |  |
| **Referrer Name** |  | **Referrer’s Phone** |  |
| **Referrer’s Email** |  | **How Referral received** |  |

**Client Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full Name** |  | | | **Gender** |  |
| **Date of Birth** |  | | | **Age** |  |
| **Address** |  | | | | |
| **Phone** |  | | | **Email** |  |
| **Are we able to leave a message** | | **Yes 🞏** | **No 🞏** | **Comment:** | |
| **Ethnicity (iwi)** |  | | | **Country of Birth** |  |

**Client’s Family Details**

Partner or Ex-partner’s name:

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | **Gender** |  |
| **Date of Birth** |  | **Age** |  |
| **Ethnicity (iwi)** |  | **Country of Birth** |  |

Please list all children under the age of 18 names and ages. Including step children or children in the clients care.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME** | **DOB** | **AGE** | **ETHNICITY** | **RELATIONSHIP TO CLIENT** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Current risks and reason for the referral**

|  |
| --- |
|  |

**Alcohol / Drug use? Yes No**

Has the client been assessed for alcohol or drug use? (Y / N)

Do you feel that the client has A & D issues that would impact on their ability to engage with ReachOut’s services? (Y / N)

If yes please give details:

|  |
| --- |
|  |

**Gambling**  **Yes** **No**

Does the client have a history of problem gambling?

Has the client received any support in relation to the gambling problem?

**Criminal History** (Violence Related Charges): **Yes**  **No**

If yes, please give details:

Does the client have a current Protection Order, Bail conditions, Probation conditions or Parenting Orders?

**Yes**  **No**

If yes, please give details:

|  |
| --- |
|  |

**Mental Health Wellbeing**

Does the client have any Mental Health risks that may impact on ReachOut staff delivering the services?

**Yes No**

If yes please give details

|  |
| --- |
|  |

Referrer’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this form to ReachOut via email [referral@avivafamilies.org.nz](mailto:referral@avivafamilies.org.nz)

P.O. Box 24161 Christchurch 8140