ATWC- Putting Families First
THERAPY SERVICES REFERRAL FORM

10 Beatty Street
P.O Box 22-363
Otahuhu
Auckland

Telephone: **(09) 276 3729**
Fax: **(09) 276 9761**
Website: **www.atwc.org.nz**

Referral date ....

Referrer Details:

Referrer:..

Name of Referrer:...

Address:...

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Phone Number:..

Mobile Phone:..

Email Address:..

Client's Details:
Please complete full contact details for each person being referred.

Client name:..

Address: ....

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Phone Numbers:..

Mobile Phone:...

Date of Birth:.. **Ethnicity**:..

Service required:

Child Psychotherapy	☐	Pacific Peoples	☐
Counselling	☐	Mellow Parenting	☐
Granger Grove	☐	Groups	☐
Parent/child work	☐	Watch, Wait and Wonder Intervention	☐
Other Parenting work	☐	School Counseling	☐

Reason for referral:
Please describe the reason for the referral.

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Background information:
Please discuss relevant client history information including social, emotional, psychological, physical, spiritual and economical details. Include previous interventions and how they have impacted on the client.

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Consent from client for referral: Yes ☐ **No** ☐
If yes was ticked please discuss client's viewpoint on the referral. If no was ticked discuss the reasons for this.

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Discuss the referrers expectations of Anglican Trust for Women and Children:
Please identify goals for the client and include any skills to learn

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Discuss the referrers role with the client:

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Other agency/significant others involvement:

Agency/Person's Name:...

Contact Person:..

Address:..

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Phone Numbers:..

Mobile Phone:...

E.mail Address:..

Involvement with Client:..

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Any Health Issues:

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Funding Details:

Date first session: .... Date last session:...................................

Agreed amount: $.................................... Total number of sessions:.....................

Payment Details:..

Is funding required for the referred service? **Yes** ☐ **No**☐
If yes ticked please include details:

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