

FAMILY START REFERRAL FORM 2022

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| FAMILY START SERVICES (AGE CRITERIA: 3MONTHS PREGNANT TO 1 YEAR OF AGE) | | | | | | | | | |
| PARENT/PRIMARY  CAREGIVER’S NAME: | | |  | | PARENT/PRIMARY  CAREGIVER’S NAME: | | |  | |
| RELATIONSHIP TO CHILD: | | |  | | RELATIONSHIP TO CHILD: | | |  | |
| AGE: |  | | DOB: |  | AGE: |  | | DOB: |  |
| ADDRESS: |  | | | | ADDRESS: |  | | | |
|  | | | |  | | | |
| PHONE: |  | | | | PHONE: |  | | | |
| MOBILE: |  | | | | MOBILE: |  | | | |
| EMAIL: |  | | | | EMAIL: |  | | | |
| ETHNICITY: |  | | | | ETHNICITY: |  | | | |
| TRIBAL AFFILIATIONS: | |  | | | TRIBAL AFFILIATIONS: | |  | | |

**BABY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| BABY’S NAME |  | | FEMALE | MALE |
| DOB/EDD: |  | NHI NUMBER: |  | |
| GP: |  | WELL CHILD PROVIDER: |  | |
| LMC: |  | ETHNICITY: |  | |

**DEPENDENTS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| NAME: |  | M | F | DOB: |  | OWN HOME: |  |
| NAME: |  | M | F | DOB: |  | HNZ RENTAL: |  |
| NAME: |  | M | F | DOB: |  | PRIVATE RENTAL: |  |
| NAME: |  | M | F | DOB: |  | BOARDING: |  |
| NAME: |  | M | F | DOB: |  |  |  |

|  |  |
| --- | --- |
| **SIGNIFICANT OTHERS (WHANAU, NEIGHBORS, FRIENDS)** | **CONTACT DETAILS** |
|  |  |
|  |  |
|  |  |
|  |  |



FAMILY START REFERRAL FORM

|  |  |  |  |
| --- | --- | --- | --- |
| **REASON FOR REFERRAL** | | | |
|  | | | |
| **ANY IMMEDIATE SPECIFIC SAFETY CONERNS** | | | |
|  | | DOGS: |  |
|  | | GANGS: |  |
|  | | OTHER: |  |
|  | |  |  |
| **REFERRAL CRITERIA** | | | |
| **LIST A.** (NEED TO HAVE AT LEAST ONE INDICATOR IN THIS SECTION) | COMMENTS (INCLUDING ANY INITIAL STRENGTHS IDENTIFIED) | | |
| **ORANGA TAMARIKI INVOLVED –** ORANGA TAMARIKI ARE CURRENTLY INVOLVED WITH MY FAMILY OR HAVE BEEN INVOLVED IN THE PAST. |  | | |
| **CHILD DEVELOPMENT –** I AM CONCERNED ABOUT MY CHILD’S DEVELOPMENT.   * I STRUGGLE WITH CARING FOR MY BABY AND MEETING THEIR HEALTH NEEDS. * I HAD LATE OR VERY LITTLE ANTE-NATAL OR POST-NATAL CARE. * MY BABY HAS A DISABILITY OR SPECIAL NEEDS. |  | | |
| **HISTORY OF CHILD ABUSE –** AS A CHILD I EXPERIENCED SOME ABUSE. |  | | |
| **ALCOHOL/DRUG/GAMBLING ABUSE –** THE AMOUNT THAT I DRINK/USE DRUGS/GAMBLE IS A PROBLEM. |  | | |
| **MENTAL HEALTH –** I HAVE OR HAVE HAD SOME ISSUES WITH MY MENTAL HEALTH. |  | | |
| **RELATIONSHIP PROBLEMS –** I HAVE HAD SOME SERIOUS PROBLEMS WITH FAMILY/PARTNER RELATIONSHIPS. |  | | |
| **YOUNG PARENT –** I AM UNDER 18, AND I HAVE OTHER CHALLENGES. (REFER TO LIST B BELOW) |  | | |
|  |  | | |

**** 

FAMILY START REFERRAL FORM

|  |  |
| --- | --- |
| **LIST B.** (NEED TO HAVE AT LEAST 3 INDICATORS IN THIS SECTION.  PLEASE PROVIDE DETAILS ABOUT HOW THEY AFFECT THE PARENT’S/CAREGIVER’S ABILITY TO CARE FOR THE CHILD. | COMMENTS (INCLUDING ANY INITIAL STRENGTHS IDENTIFIED) |
| **POLICE INVOLVEMENT –** I HAVE BEEN IN TROUBLE WITH THE POLICE. |  |
| **LOW INCOME STATUS –** I FIND IT HARD TO MANAGE WITH THE MONEY I HAVE. |  |
| **FREQUENT CHANGE OF ADDRESS –** I HAVE CHANGED ADDRESS MORE THAN ONCE IN THE LAST 6 MONTHS. |  |
| **UNSUPPORTED PARENT –** I DO NOT HAVE FAMILY OR FRIENDS AROUND TO HELP ME. I FEEL ISOLATED. |  |
| **LOW PARENTAL EDUCATION –** I STRUGGLED AT SCHOOL, LEFT EARLY AND HAVE FEW QUALIFICATIONS. I FIND LEARNING HARD. |  |
| **SUDI**  I SMOKED WHILE I WAS PREGNANT  MY BABY HAS NOT BEEN BREAST FED – OR WAS FOR A SHORT TIME ONLY.  MY BABY WAS A LOW BIRTH WEIGHT.  MY BABY WAS PREMATURE.  MY BABY WAS OR IS EXPOSED TO SECOND HAND SMOKE.  I HAVE HAD OTHER BABIES WITH LOW BIRTH WEIGHT. |  |

|  |  |  |  |
| --- | --- | --- | --- |
| REFERRER INFORMATION | | | |
| REFERRAL FROM: |  | AGENCY: |  |
| ADDRESS |  | PHONE NO: |  |
|  | E-MAIL: |  |
| DATE: |  | SIGNATURE: |  |

**IMPORTANT:** CONSENT FOR FAMILY START REFERRAL/TRANSFER

|  |  |  |  |
| --- | --- | --- | --- |
| I/WE CONSENT TO BEING REFERRED TO FAMILY START: | | | |
| CLIENT  SIGNATURE: |  | DATE: |  |

PLEASE NOTE THAT THE REFERRAL CAN BE ACCEPTED THROUGH VERBAL CONSENT.

[FSREFERRALS@ATWC.ORG.NZ](mailto:fsreferrals@atwc.org.nz)

FAX: 09 276 9761