

THERAPY SERVICES – REFERRAL FORM

Referral date:

CLIENT DETAILS

Client name:

Address:

Contact Number(s):

Date of Birth:

Ethnicity/Preferred Language:

Gender & Pronouns:

READINESS FOR THERAPY:

Transport: ☐

Availability: ☐

Childcare organised: ☐

PARENT / GUARDIAN / CAREGIVER DETAILS:

Name:

Relationship to client:

Address:

Contact number(s):

Email Address:

Additional Parent/Caregiver
Name and details:

CLIENT/GUARDIAN (IF APPLICABLE) CONSENT FOR REFERRAL:

Please note any relevant information.

Yes ☐ No ☐

SIBLINGS/CHILDREN IN HOUSEHOLD:

Full name:

D.O.B:

Full name:

D.O.B:

Full name:

D.O.B:

Full name:

D.O.B:

Full name:

D.O.B:

SERVICE REQUIRED:

Child/Psychotherapy ☐

Individual Counselling ☐

Couples Counselling ☐

Mellow Parenting ☐

Available at selected schools only

REASON FOR REFERRAL

BACKGROUND INFORMATION:

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

STRENGTHS

Please discuss protective factors for the client, including, family support, relationships, personal strengths and interests.

SAFETY & RISK:

Please discuss any concerns around self-harm, harm to others, suicidal ideation, health or any other safety concerns.

REFERRER DETAILS:

Referrer Name/Organisation:

Relationship with Client:

Address:

Contact phone number:

Email address:

DISCUSS THE REFERRERS EXPECTATIONS OF ANGLICAN TRUST FOR WOMEN AND CHILDREN:

Please identify goals for the client and include any skills to learn.

E.g. Skills to manage emotions, talk about trauma and its current understanding, understand the impact of past traumatic relationships on current and/or future relationships.

PREFERENCE OF COUNSELLOR

Female ☐ Male ☐ No Preference ☐

OTHER AGENCY/SIGNIFICANT OTHERS INVOLVEMENT:

Agency/Contact Name:

Contact number:

Email:

Relationship with Client:

AGENCY USE ONLY:

CLIENT ELIGIBILITY FUNDED SERVICES?

YES ☐	Client is a child, young person or whanau member who resides in the Counties Manukau District.
NO ☐	If not, the fee for service structure to be discussed with the client and confirmed prior to/or during the first session.