

YOUTH PROGRAMME

REFERRAL FORM



- Please answer all questions.
- If information is unavailable or a question is not applicable, please indicate so in writing.
- Incomplete referral forms cannot be processed and will be returned to the referrer.
- Post all referrals to: PO Box 8726, Symonds Street, Auckland, or fax to: 09 377 9229

CLIENT DETAILS:			
Client Name:			
Date of Birth:	Age:	Male <input type="checkbox"/>	Female <input type="checkbox"/> (please tick)
Ethnicities:		Iwi / Hapu:	
Address:			
Home Phone:	Work Phone:	Mobile:	
Email:		Occupation:	

REFERRER DETAILS:			
Referred by: <input type="checkbox"/> Self <input type="checkbox"/> Agency <input type="checkbox"/> Relative/Friend <input type="checkbox"/> Other (describe):			
Referrer Name		Position:	
Agency:		Branch:	
Address:			
Home Phone:	Work Phone:	Work Fax:	
Email:		Mobile:	

FAMILY DETAILS:			
Father's Name:		Birthplace:	
Address:			
Home Phone:	Work Phone:	Mobile:	
Iwi/Hapu:	Ethnicities:		
Email:			
Mother's Name:		Birthplace:	
Address:			
Home Phone:	Work Phone:	Mobile:	
Iwi/Hapu:	Ethnicities:		
Email:			

SUPPORT PEOPLE:

Name:		Relationship to client:	
Address:			
Home Phone:		Work Phone:	Mobile:
Iwi/Hapu:		Ethnicities:	
Email:			
Name:		Relationship to client:	
Address:			
Home Phone:		Work Phone:	Mobile:
Iwi/Hapu:		Ethnicities:	
Email:			

GUARDIANSHIP:

Who is the client's legal guardian? (tick one) Parents CYFS Other (give details)

VICTIM DETAILS:

Victim	Gender (M / F)	Relationship of the victim to the offender	Current age of victim	Victim's age range when abuse occurred
1				
2				
3				
4				

AGENCIES INVOLVED & CONTACT DETAILS

Care & Protection Social Worker:	Phone: Email:
Youth Justice Social Worker:	Phone: Email:
Community Probation Officer:	Phone: Email:

School:	Counsellor:
Other:	

CURRENT PLACEMENT:

Where will the client be placed for the duration of the assessment?

Caregiver's name & address:	Home phone:
	Mobile:
	Email:

Are there any safety concerns or care & protection issues at this placement?	For this client: <input type="checkbox"/> No <input type="checkbox"/> Yes Give details: For previous or potential victims: <input type="checkbox"/> No <input type="checkbox"/> Yes Give details:
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Is the young person living with children?	<input type="checkbox"/> No <input type="checkbox"/> Yes Give details:
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PREVIOUS PLACEMENTS:

Previous Placements:	Reasons for Leaving:
1.	
2.	
3.	
Have there been any behavioural difficulties in the above placements?	<input type="checkbox"/> No <input type="checkbox"/> Yes (give details)
Has the client ever absconded from care?	<input type="checkbox"/> No <input type="checkbox"/> Yes (give details)
Has the client ever sexually offended against another resident in care?	<input type="checkbox"/> No <input type="checkbox"/> Yes (give details)

SEXUAL BEHAVIOUR

Please describe the behaviour(s) that have prompted this referral, and include brief details with dates of the client's recent or current sexual offending or problematic sexual behaviour:

Please include with the referral any documents or reports relating to these problems

Client admits offending <input type="checkbox"/>	Client denies offending <input type="checkbox"/>
To whom has the client admitted the offending?	
Comment on the client's denial or admission (for example, is any admission consistent with other information?):	
What other data has been gathered in relation to the behaviour? <input type="checkbox"/> Evidential video or interview? <input type="checkbox"/> Police interview or summary of facts? <input type="checkbox"/> Other, please describe	
Describe other known or alleged sexual behaviours both historic and current:	

OTHER BEHAVIOURAL PROBLEMS:

Describe the client's other problem behaviours if any, for example stealing, running away, drug and alcohol use, truancy, anger problems, fire setting, self harm, suicide, etc:*

* Please include any relevant documents with the referral

DEVELOPMENTAL, LEARNING, OR MENTAL HEALTH DIFFICULTIES:

Please summarise client's history of developmental, learning, or mental health problems:*

* Please include any relevant documents with the referral

FAMILY INFORMATION:

Who are the significant members of this family involved with this client?

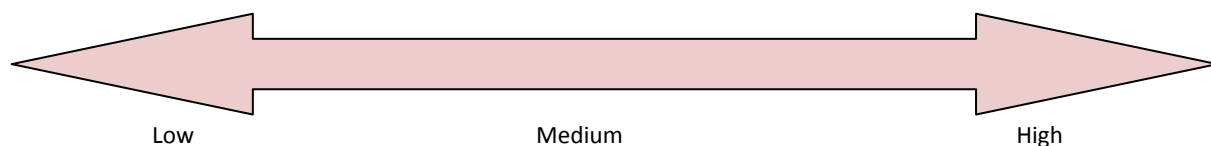
Briefly describe the client's family background (e.g. birth order, culture, significant losses, separations, etc):

What are the client's family's attitudes to the reported offending or behaviour?

Describe any family history of sexual offending or criminal behaviour:

RISK OF FURTHER HARMFUL OR PROBLEMATIC SEXUAL BEHAVIOUR:

What, in your opinion as the referrer, is your estimate of the client's risk of further harmful or problematic sexual behaviour? Please indicate by placing an X on the line in the appropriate place:



What steps have been taken so far to manage the client's risk of further harmful behaviour?

VICTIM SUPPORT:

What steps have been taken to provide for the needs of the victim(s)?

- Counselling arranged, please give the name of the counsellor(s)

- Social work arranged, please give the name of the social worker(s)

- Other, please describe

ASSESSMENT DETAILS:

Who of the family or caregivers is available to attend the assessment meetings?

How will transport be organised for the assessment?

The number of assessment sessions may vary. The most common framework involves 4 interviews over consecutive weeks for the client and their family. Assessment sessions usually last between 1 & 1 ½ hours:

REPORTS:

Please ensure the following reports, where available, are included with the referral:

<i>Report:</i>	<i>Written by:</i>	<i>Date:</i>	<i>Tick if included:</i>
Victim Impact			<input type="checkbox"/>
Summary of Evidential Interview			<input type="checkbox"/>
Police Summary of Facts			<input type="checkbox"/>
Psychological Report			<input type="checkbox"/>
Neuropsychological Report			<input type="checkbox"/>
Educational Report			<input type="checkbox"/>
Psychiatric Report			<input type="checkbox"/>
Medical Reports			<input type="checkbox"/>
CYFS Notes			<input type="checkbox"/>

OTHER COMMENTS OR ADDITIONAL INFORMATION:

Please provide any additional information or further comments that could be helpful:

COMPLETION CHECKLIST & SIGNATURE: (please tick)

Before sending the referral, please check the following and complete the authorisation below:

- All sections and information has been completed
- All reports and assessments have been included
- The family and/or caregivers have been informed about SAFE and this referral
- The referral has been signed and dated (below)

ASSESSMENT COSTS AND AUTHORISED SIGNATURE

The cost for an assessment for the Youth Programme is \$1700 plus GST (except for CYFS main contract referrals)
I authorise SAFE to invoice me or my agency for this cost

Note: A sliding scale applies for self funded, self referred clients. Please arrange this before the assessment appointment by contacting the Business Manager 09 377 9898

Treatment costs are usually covered by our funding agencies.

We make a charge for missed appointments

In making this referral I am aware that SAFE will charge me or my agency for the assessment appointment
(Signature of the person responsible for paying the assessment fee required. Unsigned referrals cannot be accepted and will be returned).

Name:	Agency:
Signed:	Position:
Date:	

SAFE CONTACT DETAILS:

Enquiries regarding the Youth Programme can be addressed to:

The Administrator on 09 377 9898 ext 702 or info@safenz.org