

SERVICE DELIVERY

Referral Form

Date:	Time: am/pm	Referral From completed by (PRINT NAME):
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REFEREE DETAILS

Contact Person:	Organisation Name:	
Address:		
Phone:	Mobile:	Fax:

REFERRED TO: (PLEASE TICK)

Silver Fern MotorSport Youth Training Programme	<input type="checkbox"/>
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REFERRED FROM (REFEREE) (PLEASE TICK)

Child Youth and Family Services	<input type="checkbox"/>
New Zealand Police	<input type="checkbox"/>
WINZ	<input type="checkbox"/>
NGO provider	<input type="checkbox"/>
Self Referral	<input type="checkbox"/>
Other	<input type="checkbox"/> (PLEASE STATE):

CLIENT DETAILS

Name:	Address	
Phone:	Mobile:	
D.O.B:	Age:	Gender:
Is currently employed?	Yes / No	<i>Details:</i>
Is currently in the care of CYF Care and Protection? (including with foster parents)	Yes / No	<i>Details:</i>
Is currently in a CYF Care and Protection Residential Facility?	Yes / No	<i>Details:</i>
Is currently in a Youth Justice Residential Facility?	Yes / No	<i>Details:</i>

ETHNICITY (PLEASE TICK)

Maori	<input type="checkbox"/>	<i>Iwi:</i>	<i>Hapu:</i>
Pacific Island:	<input type="checkbox"/>		
Pakeha New Zealander	<input type="checkbox"/>		
Asian:	<input type="checkbox"/>		

Other		(please state):
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DISCLOSURE OF RISKS

(PLEASE DISCLOSE ALL DETAIL OF RISKS AND HAZARDS KNOWN AND REFER TO ANY EXISTING RISK ASSESSMENT REPORTS, e.g., psychological assessment)

KNOWN RISK	YES (PLEASE TICK)	NO (PLEASE TICK)		
Previous history of drug use?				
Youth has current problem with drug use?				
Previous history of alcohol misuse?				
Current problem with alcohol misuse?				
Previous or current history of violent behaviour				
Mental Health Issues (if known)			(PLEASE STATE):	
Youth has behavioural problems			(PLEASE STATE):	
Is on any form of medication			(PLEASE LIST MEDICATIONS)	
Has past criminal offences			(PLEASE STATE AND SUPPLY COPY OF ALL CONVICTIONS):	
Facing current charges with the Court?			PLEASE STATE WHAT CHARGES ARE BEING FACED	
There a pending Court Case?			If "yes", provide dates (if known):	
Reports exist for this youth including CYF, Police and specialist health and behavioural reports			PLEASE LIST ALL REPORTS AVAILABLE AND WHERE THIS REPORT MAYBE LOCATED	
			REPORT NAME	LOCATION OF REPORT

PARENT/GUARDIAN CONTACT DETAILS

Please note this person will also be the first point of contact in the case of an emergency

Name:	Parent OR Guardian (PLEASE TICK)
Phone (landline):	Mobile:
Address:	

SECOND POINT OF EMERGENCY CONTACT DETAILS

Please note this person will also be the SECOND point of contact in the case of an emergency and in the case the first point of contact cannot be reached.

Name:	Parent OR Guardian (PLEASE TICK)
Phone (landline):	Mobile:
Address:	

STAFF USE ONLY

Is this Referral Accepted? Yes / No		Date:	
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IF YES	
Accepted by:	
Receipt of referral acknowledged within 72 hours	
Date of Receipt:	

IF NO	
Referring agent/person informed of reason for decline:	Verbal <input type="checkbox"/> <u>OR</u> Written <input type="checkbox"/>
Referring agent/person informed of alternative services that may assist the client:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Filed in Declined Entry to Services Folder:	Yes <input type="checkbox"/> No <input type="checkbox"/>

Comments:

Print this form and post to: Silver Fern MotorSport Charitable Trust, P.O Box 48156 Blockhouse Bay, Auckland 0644, New Zealand