

 Office Phone: 094396070 Email: sosreferrals@soskaipara.co.nz

**Referral Form**

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| **Referrer Information:** |
| Date:  |  | Time: |  |
| Referral From: |  | Agency:  |  |
| Phone: |  | Email address: |  |

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| **Client Information:** |
| Name: |  | Phone: |  |
| Age/DOB: |  | Ethnicity & Iwi: |  |
| Address: |  |
| Name/s of legal caregiver/s if referral is for a child or young person: |  |
| Number of children & Age:  |  |

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| **Reason for referral:** |
| **Family Harm:** | **Yes / No** | **Sexual Harm:** | **Yes / No** |
| **Current agencies/counsellors involved** *Continue on next page if needed* |  |
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| *Include any risks S.O.S need to be aware of: (aggressive behaviour, charges pending, offences, mental health, care and protection, any other safety concerns, ie threats from others to client or staff)* *Continue on next page if needed.* |
| **Family Violence perpetrator name**:  |  | **Current Protection Order (PO):**  | **Yes**  **/ No**  |
| **Family Court where PO was granted:**   |  | **If no PO, has a charge related to domestic violence in a criminal court been made** | **Yes / No** |

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| **Current agencies/counsellors involved:** |  |
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