SOS KAIPARA

Referral Form

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

Referrer Information:		
Date:		Time:
Referral From: (Name)		
Agency/Organisation:		
Phone:		
Email address:		
Relationship to Client:		
Has the client consented to this referral? ☐ Yes ☐ No		

Client Information:	
Full Name:	
Preferred Name: (if different)	
Phone:	
Preferred Contact Method: ☐ Phone ☐ Text ☐ Email	
Date of Birth: Age: (if DOB unknown):	Gender: Pronouns (optional):
Ethnicity:	Iwi:
Address:	
Interpreter Required? ☐ Yes ☐ No If yes, which language:	
Number of Children and Ages:	
If the Client is a Child or Young Person: Name of Legal Caregiver:	
Phone Number of Caregiver:	

Reason for referral: **Type of Harm (Tick all that apply)**
☐ Family Harm ☐ Sexual Harm ☐ Other (please specify)
Is the person currently living with the person causing harm? Yes ☐ No ☐
Is the person causing harm aware of this referral? Yes ☐ No ☐
Please describe the reason for referral:

Current Agencies/Counsellors Involved			
Agency	Name	Role	Contact Info

Risk and Safety Concerns
Include any risks SOS should be aware of:
Risks to client: (e.g. threats from others, mental health, homelessness)
Risks posed by client: (e.g. aggression, criminal charges)
Risks to staff: (e.g. stalking, intimidation)

Family Violence Perpetrator Information
Name of Person Causing Harm:
Current Protection Order (PO): ☐ Yes ☐ No
If yes, which Family Court granted the PO:
Has a criminal charge been laid? ☐ Yes ☐ No

Privacy and Consent
Please ensure the client has given informed consent for this referral.

SOS OFFICE USE ONLY

Referral Received by: _____Date Received: _____

Referral Method: ☐ Phone ☐ Email ☐ Walk-in ☐ Other

Priority Level: ☐ High ☐ Medium ☐ Low

Referred To:

☐ **Counselling**
- ☐ Non-ACC
- ☐ ACC

☐ **Education Programmes**
- ☐ Women's Empowerment
- ☐ Parenting
- ☐ Safety Programme

☐ **Support Services**
- ☐ Crisis Support
- ☐ Safe Accommodation
- ☐ Creative Arts

Assigned Worker: _____