**KAKE ORANGA HĀHI KATORIKA – CATHOLIC FAMILY SUPPORT SERVICES WAIKATO COMMUNITY REFERRAL FORMS**

100 Morrinsville Rd

PO Box 24010

Hamilton 3216

Phone: 07 856 3760

Email: referrals@cfss.org.nz

**WAIKATO REFERRER DETAILS**

|  |  |
| --- | --- |
| **Name of Referrer** |  |
| **Organisation/Service** |  |
| **Date** |  |
| **Phone#** |  |
| **Mobile#** |  |
| **Email** |  |
| **Supervisors Name** |  |
| **Supervisors Mobile #** |  |
| **Supervisors Signature** |  |

**CLIENT DETAILS**

|  |  |
| --- | --- |
| **Full Name** |  |
| **Address** |  |
| **Home Phone:** |  |
| **Mobile #** |  |
| **Address** |  |
| **Email Address** |  |
| **Date of Birth** |  |
| **Ethnicity** |  |
| **Iwi** |  |

**CAREGIVERS NAME**

|  |  |
| --- | --- |
| **Full Name** |  |
| **Address** |  |
| **Home Phone:** |  |
| **Mobile #** |  |
| **Address** |  |
| **Email Address** |  |
| **Date of Birth** |  |
| **Ethnicity** |  |
| **Iwi** |  |

**CHILD/RENS NAMES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name(s)** | **Date of Birth** | **Age** | **Gender** | **Ethnicity** |
|  |  |  |  |  |
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|  |  |  |  |  |
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|  |  |  |  |  |

**IF REFERRAL FOR SUPERVISED CONTACT – PROVIDE DETAILS OF THOSE TO HAVE CONTACT**

|  |  |
| --- | --- |
| **Name** |  |
| **Mobile #** |  |
| **Address** |  |
| **Gender** |  |
| **Ethnicity** |  |

**REFERRERS CONCERNS/ REASON FOR REFERRAL**

**WHANAU/FAMILY BACKGROUND INFORMATION**

**(Please also list any other agencies, if involved, and their contact details)**

**SAFETY PLANS (**If there is safety plan, please provide brief outline or attach).

**IS FAMILY/ WHANAU AWARE AND/ OR CONSENTED TO REFERRAL YES/ NO**

**NUMBER OF HOURS:**

Please allow for travel and administration time.

|  |  |
| --- | --- |
| **Review date** (if relevant)**:** |  |

|  |  |
| --- | --- |
| CFSS Client Number # |  |
| Date CFSS Received Ref |  |
| Date Database Entry |  |

**OFFICE USE ONLY**