COUNSELLING SERVICE
REFERRAL FORM

Client Name:	D.O.B	
Address:		
Do all legal guardians agree to child receiving counselling	Yes	No
Mother's Name: (if client is under 18yrs)	D.O.B	
Address:		
Contact Number:		
Email:		
Father's Name: (if client is under 18yrs)	D.O.B	
Address:		
Contact Number:		
Email:		
Caregiver's Name: (if client is under 18yrs)	D.O.B	
Address:		
Contact Number:		
Email:		
Referrer Details Name: Agency:	Contact No:	
Have you informed the client the referral has been made	Yes	No

2020 version

Reason for referral:

Type of counselling requested: Child, Youth, Family, Couple, or Adult

Any safety or legal issues?

Legal orders in place: -

Custody Orders		Yes	No	Please Specify
Parenting Orders	Court	Yes	No	
appointed access		Yes	No	
Protection Orders		Yes	No	
Trespass Orders	Other	Yes	No	

Please provide more information about the client:

- Oranga Tamariki has been involved in the past Yes No
- Oranga Tamariki currently involved Yes No
- Experienced family violence Yes No
- Alcohol or substance abuse Yes No
- Parenting concerns Yes No
- Mental health issues Yes No
- Used Home and Family services in the past Yes No

OTHER MAIN CAREGIVERS/PROFESSIONALS/AGENCIES INVOLVED:

Name	Role/Agency	Phone

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TE WHARE MANAAKI TANGATA
PO BOX 287 Christchurch
e: contact@homeandfamily.net.nz www.homeandfamily.net.nz