

DATE:

## REFERRAL / INTAKE SHEET

REFERRAL SOURCE:

REFERRER'S PHONE:

DUTY WORKER:

ALLOCATED TO:

CLIENT / PARENT / CAREGIVER:

DOB

SEX

ETHNICITY

IWI

ADDRESS:

PHONE: (MOBILE)

(WORK)

(HOME)

EMAIL:

PREFERRED CONTACT

TXT:

EMAIL:

MOBILE:

HOME:

VOICEMAIL:

DEPENDENT CHILDREN

DOB

SEX

ETHNICITY

IWI

FAMILY COMPOSITION (PLEASE TICK)

Single Parent

Two Parent (birth)

Two Parent (step)

Individual

Couple

Other

Current or potential risk to the child / adult / self-safety?

COMMENTS:

URGENCY / AVAILABILITY:

ISSUES

Child's Behaviour or Needs

Effects of Violence or Abuse

Parenting Skills

Grief

Relationship Problems

Mental Health Issues

Effects of Addictions



**SERVICE REQUESTED - REFERRALS CLOSED AT PRESENT**

Couns. Individual  
Couns. Family

Couns. Couple

**PSYCHOLOGY**

Child and Family  
Social Work

Learning Assessment  
Community Connector

Are you on a waiting list elsewhere? (please tick)

**Where did you hear about our services?**

**Are you a previous client of CSS? (please tick)**

Family / Friend

Health Care Provider

Church

Oranga Tamariki

School

Other CSS Programme

Other Agency

**PREVIOUS REASON / ISSUE:**

**WHEN:**

**WITH WHOM:**

**BRIEF SUMMARY OF REASON FOR REFERRAL:**

CSS staff use this information to respond to your request for a referral and manage the process thereafter.

We will not disclose your information to third parties unless we have your consent, or if we are required to by law.

We take all reasonable precautions to keep your information safe and secure.

[catholicsocialservices.nz](http://catholicsocialservices.nz)



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