

Adult Services Referral Form

18 years and over



- Please answer all questions
- If information is unavailable or a question is not applicable, please indicate this.
- Incomplete referral forms cannot be processed and will be returned to the referrer.
- Referrals can be sent to: PO Box 8726, Symonds Street, Auckland 1150 | Faxed to 09 377 9229

PERSON BEING REFERRED DETAILS:

| | | | |
|--------------------------------|-------------|-------------|--|
| Name of person being referred: | | | |
| Date of birth: | / | / | Age: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender-diverse |
| Ethnicity: | Iwi / Hapu | | |
| Address: | | | Postcode: |
| Home phone: | Work phone: | Mobile: | |
| Email: | | Occupation: | |

REFERRER DETAILS

| | | | | |
|-----------------|-------------------------------|---------------------------------|------------------------------------|--|
| Referred by: | <input type="checkbox"/> Self | <input type="checkbox"/> Agency | <input type="checkbox"/> Relative: | <input type="checkbox"/> Other – please describe |
| Referrers name: | Position: | | | |
| Agency: | Branch: | | | |
| Address: | | | | Postcode: |
| Home phone: | Work phone: | Mobile: | | |
| Email: | | | | |

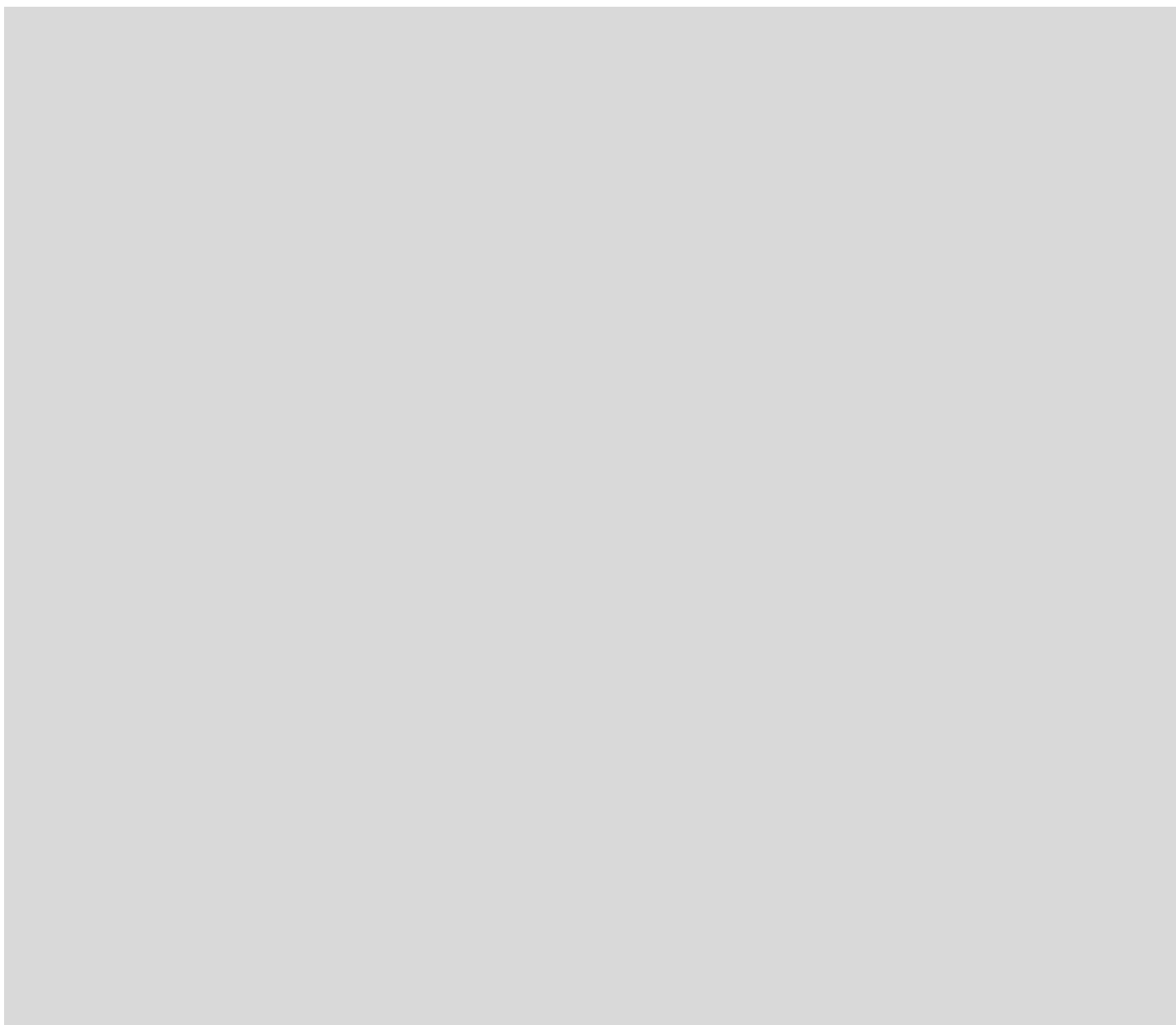
SUPPORT PEOPLE AND FAMILY CONTACT DETAILS

| | | |
|--|-------------|-----------|
| Name: | | |
| Relationship to person being referred: | | |
| Address: | | Postcode: |
| | | |
| Home phone: | Work phone: | Mobile: |
| Email: | | |
| Name: | | |
| Relationship to person being referred: | | |
| Address: | | Postcode: |
| | | |
| Home phone: | Work phone: | Mobile: |
| Email: | | |

LEGAL SITUATION

| | | |
|---|-----------------------------|---|
| Is there a court case pending? | <input type="checkbox"/> No | <input type="checkbox"/> Yes – sentencing date is / / |
| Is the person being referred currently in prison? | <input type="checkbox"/> No | <input type="checkbox"/> Yes – likely release date is / / |
| Is the person being referred on a community-based sentence? | <input type="checkbox"/> No | <input type="checkbox"/> Yes – details of sentence below: |
| Home detention | Start date is / / | End date is / / |
| Supervision | Start date is / / | End date is / / |
| Parole/release conditions | Start date is / / | End date is / / |
| Person being referred PRN number (required): | | |

Special conditions:



Offence(s)

Has the person being referred (the client) ever been the victim of sexual abuse? ☐ Yes ☐ No

Has the person being referred ever lodged an Integrated Sensitive Claims (ISCC) with ACC ☐ Yes ☐ No

Please include any documents or reports relating to past or current legal situation(s).

DETAILS OF HARMFUL SEXUAL BEHAVIOUR

Please provide a brief description of the harmful sexual behaviour.

VICTIM DETAILS

| Victim | Gender (M/F) | Relationship of the victim to the person being referred | Current age of victim | Victims age range when harmful sexual behaviour occurred |
|--------|--------------|---|-----------------------|--|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

SUPPORT

Please indicate what steps have been take to address the needs of children affected by the harmful sexual behaviour and provide the names of counsellors and/or social workers involved with them:

OTHER AGENCY INVOLVEMENT *(if any)*

Describe current or past history of any other agency involvement, if any:

Please include with the referral any document or reports relating to other agency involvement.

REPORTS

Please ensure the following reports, where available are included with the referral:

| Report | Written by | Date: | <input checked="" type="checkbox"/> if included |
|---|------------|-------|---|
| Victim Impact | | | <input type="checkbox"/> |
| Summary of evidential review | | | <input type="checkbox"/> |
| Police summary of facts | | | <input type="checkbox"/> |
| Sentencing notes | | | <input type="checkbox"/> |
| Psychological Report | | | <input type="checkbox"/> |
| Neuropsychological Report | | | <input type="checkbox"/> |
| Educational Report | | | <input type="checkbox"/> |
| Psychiatric Report | | | <input type="checkbox"/> |
| Medical Reports | | | <input type="checkbox"/> |
| CYF notes | | | <input type="checkbox"/> |
| Traffic and Criminal Conviction history | | | <input type="checkbox"/> |
| Provision and Advice to the Courts | | | <input type="checkbox"/> |
| ASRS Score (Corrections only) | | | <input type="checkbox"/> |
| Other: | | | <input type="checkbox"/> |

OTHER COMMENTS OR ADDITIONAL INFORMATION

Please provide additional information or comment further on any of the above sections:

COMPLETION CHECKLIST AND REFERRER SIGNATURE

☒ **Before sending the referral, please check the following and sign below:**

☐ All sections and information have been completed

☐ All reports and documents have been included

☐ The referrer has signed and dated the referral below. **Unsigned referrals will not be accepted**

☐ **The person being referred acknowledges and agrees with the referral being made.**

Referrer's signature:

Date: / /

ADDITIONAL NOTES:

