**

Seuga Programme**: Referral Form**

**Referral Details:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Organisation/Church**  **Community** |  | | | | **Date of Referral** |  |
| **Time of Call** |  | | | | **Duration of Call** |  |
| **Referrer Name** |  | | | | **Referrer’s Phone** |  |
| **Referrer’s Email** |  | | | | **How Referral received** |  |
| **Has the person given consent?** | | **Yes** | **No** |

**Client Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full Legal Name** | |  | | | | | | | | | | **Gender** | |  | |
| **Matai/Chiefly Names** | |  | | | | | | | | | | | | | |
| **Date of Birth** | |  | | | | | | | **Age** | | | |  | | |
| **Address** | |  | | | | | | | | | | | | | |
| **Phone** | |  | | | | | | | **Email** | | | |  | | |
| **Are we able to leave a message** | | | | **Yes** | | | **No** | |  | | | | | | |
| **Ethnicity (Pacific Island)** | |  | | | | | | | **Country of Birth** | | | |  | | |
| **If you were born overseas, when did you arrived in New Zealand?** | | | | | | | | | |  | | | | | |
| **Do you speak and understand English?** | **Fluent** | |  | | **Fair** |  | | **Understand some** | |  | **Cannot speak English** | | | |  |
| **Can you speak and understand another Pacific Island language, and which Pacific language(s)?**  **Please write down Pacific Island languages that you can speak:** | | | | | | | | | | | | | | | |

**Client’s Family Details:** Partner or Ex-partner’s name:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Full Legal Name** |  | | | **Gender** | |  |
| **Matai/Chiefly Names** |  | | | | | |
| **Date of Birth** |  | **Age** |  | | | |
| **Ethnicity** |  | **Country of Birth** |  | | | |
| **If your partner/ex-partner was born overseas, when did he/she arrived in New Zealand?** | | | | |  | |

Please list all children under the age of 18 names and ages. Including stepchildren or children in the client’s care.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME** | **DOB** | **AGE** | **ETHNICITY** | **RELATIONSHIP TO CLIENT** |
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**Current risks and reason for the referral**

|  |
| --- |
|  |

**Alcohol / Drug use?**  **YES/NO**

Has the client been assessed for alcohol or drug use?

Do you feel that the client has A & D issues that would impact on their ability to engage with SEUGA services?

**Gambling** **YES/NO Unknown**

Does the client have a history of problem gambling?

Has the client received any support in relation to the gambling problem?

**Criminal History** **YES/NO**

If yes, please give details:

Does the client have a current Protection Order, Bail conditions, Probation conditions or Parenting Orders?

**Yes**  **No**

If yes, please give details:

Does Oranga Tamariki have any current involvement with the family? **Yes No**

If yes, please give details:

**Mental Health Wellbeing**

Does the client have any Mental Health risks that may impact on SEUGA staff delivering the services?

If yes, please give details:

Referrer’s signature: Date:

Please return this form to SEUGA via email [referral@aviva.org.nz](mailto:referral@aviva.org.nz)

P.O. Box 24161 Christchurch 8141