Referral / Client Intake

whare manaaki CENTRALCONNECT

Referrer *(agency, family, friends or self-referral by client)*			
Referral Date	/ /	Referral Person	
Referral Agency		Referrer Contact Phone	
Client consented to referral?	Yes / No (circle)	Referrer Contact Email	
Main reason(s) for this Referral			
With our support, what do you (the client) want to achieve?			
Urgency of your (or Client) Situation		High / Medium / Low (circle please)	

Client Details			
Last Name		First Name(s)	
Date of Birth		Country of Birth	
Gender		Ethnicity	
IWI		Hapu	
Street name		City	
Home Phone No		Leave Message is OK?	
Mobile No		Work Phone Number	
Best way to contact	Phone / mobile / email (circle)	Email address	
Best time to contact		Can we mail you a letter on the above address?	☐ Yes ☐ No
Do you have a disability (e.g. hearing loss)	☐ Yes ☐ No	What Disability?	
Is the client in regular contact (family or otherwise) with any children under the age of 17		Please provide names and details	

Health & Safety *(all fields must be completed)*			
Is the client under 17 years?	☐ Yes ☐ No	If so, are you worried about the client's safety?	☐ Yes ☐ No
Are there other children in the direct family?	☐ Yes ☐ No	If so, are you worried about these children's safety?	☐ Yes ☐ No
Are there any other safety issues in your home environment our staff should be aware of? (For instance: there are dogs or weapons present, or drugs used, involvement with gangs or a history of violence). Please provide details:			

Legal Guardian, Primary Caregiver of Client or Next-of-Kin *(if client is under 17 years old)*			
Name		Contact Phone No	
Address		Relationship to Client	Legal Guardian / Primary Caregiver *(Please circle)*

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Other Agencies Involvement *(are there any other **agencies** involved with this family/whanau; for instance other social agencies, CYF, social worker in schools, school, GP, Mental Health)*			
Child, Youth and Family Involvement	Yes / No (please circle and if Yes, write down if it is current or in the past. Also provide social worker name and contact phone)		
Doctor / GP	Name: Dr	Medical Practice	
Other Agencies involved with Family/Whanau	**Current Involvement**		**Involvement in the past** *Specify the year(s)*
	Contact Person	**Phone number**	

Children / Siblings		
First and Last Name	**Gender**	**Date of Birth**

Family/Whanau members which need to be included in this Referral			
Do you want your Family / Whanau involved in the service we provide to you?			☐ Yes ☐ No
Full Name		Date of Birth	
Relationship to Client		Contact Phone No	
Address		Ethnicity	
IWI		Hapu	
Full Name		Date of Birth	
Relationship to Client		Contact Phone No	
Address		Ethnicity	
IWI		Hapu	
Full Name		Date of Birth	
Relationship to Client		Contact Phone No	
Address		Ethnicity	
IWI		Hapu	
Full Name		Date of Birth	
Relationship to Client		Contact Phone No	
Address		Ethnicity	
IWI		Hapu	
Full Name		Date of Birth	
Relationship to Client		Contact Phone No	
Address		Ethnicity	
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Client Consents / Confidentiality / Viewing of your file
By Signing this form, you (the Client) give permission for Central Connect to enter the information of this referral and subsequent client service information on our Client Management Database for the purpose of Central Connect's management of services provided to you.
Client information is confidential and not disclosed to any other party unless approved by you in writing. However Central Connect must disclose client information to a third party in the following situations: • On request from Government agencies we must provide client information under statutory law or as part of the government contracts we hold. This also may include government audits of the services we provide. • If keeping that confidentiality would mean that the safety of the client (and/or Family/Whanau/other person(s)) may be compromised in the view of the practice professional(s) of our agency, our concern may be notified to Policy and/or Child, Youth and Family. • When there is a concern for a child's safety, we will first discuss this concern with you. However, this concern may also be referred to Child, Youth and Family.
You are able to view your file in the Central Connect's office by putting your request in writing to the Manager.
Clients consent(s) given to Central Connect *(This enables the Central Connect practitioner for instance to talk about your situation with a medical practitioner or the lawyer when that is relevant to the Central Connect service provided to you.)*

Agency and/or Person Name	Consent for the Purpose of	Client Signature

Any Further Comment
Comment

Central Connect's Complaints Procedure
If you are concerned about any aspect of our services, please request to speak to the Manager or the Chair of our Governance Board. At reception you can ask also for a copy of our Complaints Policy and a Complaints form. When returning the completed complaints form, please enclose it in an envelope and address it to The Manager or the Chair of the Governance Board.

Client Signature *(Client, Guardian or Primary Caregiver)*			
Name		Date	/ /
If not the Client, relation to Client	Legal Guardian / Primary Caregiver Please circle	Signature	

For Central Connect staff use only			
Date referral entered onto Exess	/ /	Exess Client Number	CC
Data entry worker name		Initials	
Intake Coordinator name		Referral accepted?	☐ Yes ☐ No
Intake Coordinator signature		Intake date	/ /
If declined what is the reason			
Staff Comment		Staff initials	