Referral to CAPS Hauraki

Click here to email to capsthames@capshauraki.co.nz

Date of Referral: _____

Name & Organisation of Referrer:_____

Contact Number of Referrer: _____

Referral taken by: _____

How did you hear about our service:_____

Client Details:

Name: _____

Address:_____

Phone Numbers: _____

Gender: F / M /Other _____ Date of Birth: _____

Ethnicity: _____ Iwi: _____

Emergency Contact: _____ Phone:_____

How would you like us to contact you? Phone ☐ Text ☐ Email ☐ (Email address)_____

Can we leave a voicemail: ◯ Yes ◯ No Send letters: ◯ Yes ◯ No

Do you have children in your care ◯ Yes ◯ No

If the client is a child, please complete the names of their Parent, Guardians or Caregivers:

Name of Parents, Guardian or Caregiver	Address	Contact Phone No.

Reason for Referral:

_____

_____

_____

_____

_____

_____

_____

What type of support are you looking for :

☐ Social Work ☐ Counselling ☐ Youth Work ☐ Sexual Abuse Support ☐ DV Programme

☐ Other _____

Referring Agency will continue to be involved?		Client has consented to referral?	
◯ YES	◯ NO	◯ YES	◯ NO
Do you have a Protection Order?			
◯ YES	◯ NO		

Please list other agencies involved:
Any current Family Court Proceedings: