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| **Referral to Stepping Stone Youth Services** |
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| This form can be used to refer a Client to any Stepping Stone Youth Services. Please select any of the options you are interested in referring to: |
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|[ ]  **Residential** |
|[ ]  **Respite** |
|[ ]  **Mobile** |
|[ ]  **Community Support Work** |
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| If you wish to discuss which services might be appropriate for the Client you are referring, please phone 03 338 6390 ext. 735. For Respite Referrals, please make contact directly with the Youth Residential and Respite Service to discuss a booking (03 338 7259). |
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| **CLIENT DETAILS** |
| Name: |  | NHI: |  |
| Date of Birth: |  | Gender: |  |
| Ethnicity: |  | Contact Phone Number: |  |
| Address: |  |
|  |
| **NEXT OF KIN DETAILS** |
| Next of Kin’s Name & Relationship to Client: |
| Next of Kin’s Address: |
| Next of Kin’s Contact Phone Numbers: |
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| **REFERRER’S DETAILS** |
| Name: | Agency: |
| Contact Details: |  |
| If this referral is being made by someone other than the Case Manager for this Client, please indicate who their Case Manager is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is the Case Manager aware that this referral is being made? |
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| **CLIENT INFORMATION** |
| Legal Status (Mental Health Act, CYFS Act, Bail Conditions): |
| Client’s Diagnosis: |
| Other Symptoms: |
| Psychiatrist:  | Agency: |
| Current Medications: |
| Physical Health Issues & Allergies: |
| Objectives to Referral to SST Services: |
| Likely Signs of Deterioration in Mental Health: |
| Safety Concerns (Criminal History/Behaviour, Aggression, Property Damage): |
| Alcohol and Drug Usage/History: |
| Client’s Current Daily Activities: |
| Any Gender Issues that Staff should be aware of? |
| Other Organisations the Client is involved with? |
| Client Strengths: |
| What insights does this Client have about their Mental Health? |
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| **RESPITE ONLY:** |
| Do you have Respite dates in mind for this Client? |
| Can this Client come and go from the house? |
| Any conditions on the Client coming and going from the house? |
| If an early discharge is required due to incident, what is the plan for where they will go? |
| If the Client goes AWOL, what/who should be our first point of contact? |
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| **MOBILE & COMMUNITY SUPPORT WORK ONLY:** |
| Are there any issues around SST Staff going to this Client’s home address? |
| Are there any specific dangers for the Client at the current address? |
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| Referrer’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **This form can be submitted via:*** Email: youthreferrals@stepstone.org.nz
* Post: PO Box 33103, Barrington, Christchurch 8244
* Fax: 03 338 6398
* For Respite referrals, please send the referral to the Youth Residential and Respite Service and to the SPOE Co-ordinator. Respite email: yresidential@stepstone.org.nz; Fax: 03 338 7262

*We will be in touch with you as soon as possible after receiving this referral.* |