**Please complete this form and send to: Aland Fish, Youth and Community Services Manager, SST.**

**Email:** crfssreferrals@stepstone.org.nz **or Phone: 027 471 4425**

* Caroline Reid Family Support Service supports children who live in families in which parental mental illness is adversely affecting the child(ren).
* Intake is for children aged 7-16 years.
* Intake for the long-term service is for children aged 7-11 years.

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| Referred by: |  | Referral Date: |  |
| Agency: |  | Phone: |  |
| Address: |  | Email: |  |

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| **Referral Criteria (\* mandatory):** | **Tick:** | **Comments:** |
| \* One parent with diagnosed mental illness | □ |  |
| Two parents with diagnosed mental illness | □ |  |
| \* Parental mental illness chronic and/or complex | □ |  |
| Sibling with mental illness | □ |  |
| \* Child adversely affected by parental mental illness | □ |  |
| \* Child does not have a mental illness | □ |  |
| Poor parenting performance | □ |  |
| Disturbed parent/child bond | □ |  |
| Family lacks supports | □ |  |
| Financial difficulties in family | □ |  |
| Significant family stress | □ |  |
| Child has behaviour problems | □ |  |
| Child has anxiety symptoms | □ |  |
| Child is bullied at school | □ |  |
| Child has learning difficulties | □ |  |
| Child struggles to socialise with peers | □ |  |
| CYFS involvement | □ |  |
| Alcohol and other drug issues in family | □ |  |

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| **Referral for** |
| Child (client) Name: |  | NHI: |  |
| Ethnicity / Iwi: |  | Gender: | M / F / Other |
| School Year: |  | School: |  |
| D.O.B: |  | Teacher: |  |
| Address: |  |
| Phone numbers: |  |

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| **Legal Guardian details** |
| **Mother’s Name:** |  | NHI: |  |
| Ethnicity / Iwi: |  | D.O.B: |  |
| Address: |  |
| Phone numbers: |  |
| **Father’s Name:** |  | NHI: |  |
| Ethnicity / Iwi: |  | D.O.B: |  |
| Address: |  |
| Phone numbers: |  |
| **Other siblings / children:** |
| Name: | D.O.B: | Gender: | Ethnicity / Iwi: | Resides with: |
|  |  | M / F / Other |  |  |
|  |  | M / F / Other |  |  |
|  |  | M / F / Other |  |  |
|  |  | M / F / Other |  |  |
|  |  | M / F / Other |  |  |

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| Details regarding Parental diagnosis: |  |
| Presenting issues for the Child: |  |
| Medical issues / allergies for the Child: |  |
| Presenting issues for the Parents / family: |  |
| Safety issues (e.g. criminal justice involvement, history of illegal / unsafe activities, inappropriate sexual behaviour, aggression, dog on property: |  |

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| **What type of Service do you feel is needed?** | **Tick one only** |
| **3-month brief intervention** with child/ren and family, which includes the Children understanding Mental Illness (CUMI) programme, Parenting with mental distress, liaison with other services, and established referrals to other services. | □ |
| **Long term intervention** with child/ren and family which includes the above, but also with a particular focus on development of mentoring relationships with the child and parents/family members, and provision of regular recreation activities in which the child/ren meets and gets to know other children from similar situations. | □ |

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| **Agencies involved with the Child** |
| GP: |  | Phone: |  |
| Contact Person: |  | Mobile: |  |
| Email: |  | Fax: |  |

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| Agency: |  | Phone: |  |
| Contact Person: |  | Mobile: |  |
| Email: |  | Fax: |  |

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| Agency: |  | Phone: |  |
| Contact Person: |  | Mobile: |  |
| Email: |  | Fax: |  |

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| **Agencies involved with the Parents / Family** |
| Case Manager: |  | Phone: |  |
| Location: |  | Mobile: |  |
| Email: |  | Fax: |  |
| Psychiatrist: |  |

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| GP: |  | Phone: |  |
| Practice Name: |  | Mobile: |  |
| Practice Nurse: |  | Fax: |  |

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| CSW: |  | Phone: |  |
| Location: |  | Mobile: |  |
| Email: |  | Fax: |  |
| Needs Assessor: |  | Location: |  |

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| Agency: |  | Phone: |  |
| Contact Person: |  | Mobile: |  |
| Email: |  | Fax: |  |

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| --- | --- | --- | --- |
| Agency: |  | Phone: |  |
| Contact Person: |  | Mobile: |  |
| Email: |  | Fax: |  |