YOUTH HORIZONS | KIA PUĀWAI

Our youth, our future

FFT/MST/FirstCare Referral Form

Referrer details:			
Referral made by			
Date of referral			
Oranga Tamariki social worker			
DDI		**Mobile**	
E-mail			
Length of time involved with this case		**Oranga Tamariki office**	
Oranga Tamariki supervisor		**DDI**	
Supervisor's e-mail			
Gateway	**Please attach referral & assessment if available**		

Requested service: **(Please note YH may triage to a different service, in which case we will discuss with you)**									
FFT		**MST**		**Triple P**		**CBT**		**Incredible Years**	
Please indicate previously tried interventions:									

Young person details:									
Surname / family name									
First names									
Date of birth						**Gender**		**M F**	
Place of birth (include town, city and country)						**NHI number**			
Ethnicity						**Iwi/village**			
Oranga Tamariki status and agreement to keep case open for duration of treatment									
Others in the household									
Sibling(s):									
Name		**D.O.B**		**Ethnicity**		**Gender**		**Referred (Y/N)**	

Caregiver Details:			
Current caregiver(s)			
Address			
Phone		**Mobile**	
Length of time at current placement		**Relationship to child**	

Reason for referral: (please describe behavior at home, school and goals for this intervention).
Please indicate any safety concerns: (visiting the home / care and protection / non-association orders)

Parents details: (if not current caregivers)			
Name		**Name**	
Address		**Address**	
Phone		**Phone**	
Others living with parent (siblings, partners, others)		**Others living with parent** (siblings, partners, others)	

Other services involved:		
Agency	**Contact person**	**Contact details**

This section must be completed for referral to proceed:			
Oranga Tamariki consents to referral	Y	N	Consent obtained by:
Parent/caregiver(s) have consented to a Service Planning Appointment	Y	N	Consent obtained by:

Auckland referrals:
The completed referral form can be sent to
E-mail: aucklandreferrals@youthorizons.org.nz
Post: PO Box 22365, Otahuhu, Auckland, 1640
Fax: 09 573 0959 (Attention SBSS Referrals)