The Mount Cargill Trust

"Valuing - Individuals - Enhancing Lives"

Referral Information

(Please return to: PO Box 2462, Dunedin 9044)

Name: ……………………………………………………………………………

Date of Birth: ……………………………… **Age**: ………………………

Date of Referral: ……………………………

Referred by: ……………………………………………………………………

Current Address: ……………………………………………………………

……………………………………………………………………

Ethnicity: ……………………………………..

Languages Spoken at Home: …………………………………………….

Iwi (*If applicable*): ……………………………………………………………..

Community Services Card: YES/NO

If Yes, Number: ………………………….. Expiry Date: ………………

Names of Parents:

Mother: ……………………………………………………………………..

Address: ……………………………………………………………………

……………………………………………………………………

Telephone: Home: ……………………………………….

Work: ……………………………………….

Mobile: ……………………………………….

Father: ……………………………………………………………………

Address: ……………………………………………………………………

……………………………………………………………………

Telephone: Home: ……………………………………….

Work: ……………………………………….

Mobile: ……………………………………….

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Names of Guardians/Foster Parents:

Names: ……………………………………………………………………..

Address: ……………………………………………………………………..

……………………………………………………………………..

Telephone: Home: ……………………………………………

Work: ……………………………………………

Mobile: ……………………………………………

Referral Agent:

Name: ………………………………………………….

Relationship: ………………………………………………….

Address: ………………………………………………….

………………………………………………….

Telephone: ………………………………………………….

Referral Summary (*significant points)*

Copy of any orders (CYFs)

Other Services involved with this family/child/young person: e.g. CYF, ACC, YSS, I.D.S, Access Ability. *(Please include all relevant reports)*

Other Support systems already in place:

Needs Assessment Completed? *(if applicable)* Yes/No

Date Completed: ……………………………….

Copy Enclosed: Yes/No

Is there a Residential Support Subsidy in place?
(*if applicable)* Yes/No

Level: ……………………………………………..

Respite Care – Care Support Days available?
(*if applicable)* Yes/No

Specialists Involved: (*Any appointments requiring follow up)*

Current Living Placement:
(*Please describe environment fully and detail concerns)*

Family/Whanau Relationship:

Name	Relationship	D.O.B	Gender

Home Environment:

Child/Young person's relationship with:

Parents/Caregivers:

Siblings:

Other Adults:

Peers:

Authority Figures:

Developmental History:
(e.g. birth trauma, milestones, early medical diagnosis)

Is there any forensic history? (*Please specify)*

Psychometric testing:

IQ Range:

Test Used:

Comment:

Behaviours of concern:

Home Context:

School Context:

Interventions:

What interventions have been tried for these behaviours?

Outcomes of interventions:

Has this application been discussed with the child/young person?
(*If **No** – please outline reasons. If **Yes** – please describe their reaction/attitude)*:

<u>History</u>:

Has the child/young person displayed any sexualised behaviours?

Please detail the behaviours:
(Specific nature – contact with adults/young persons/peers/younger children)

<u>Is there any history of the following</u>:
(*If **Yes** - please specify in detail)*

Violent behaviour:

Arson/Fire lighting:

School aggression:

Home aggression:

Is there any history of the following – Continued:
(*If **Yes** - please specify in detail)*

Property damage:

Use of weapons:

Criminal convictions:

Youth Aide intervention:

Solvent/Drug abuse:

Self mutilation:

Suicidal ideation:

(Please attach any Reports)

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Healthcare Providers' Information

Doctor/GP: ………………………………………………………………..

Address: ……………………………………………… ………………

Phone No: ……………………………………………… ………………

Dentist: ……..………………………………………...……………

Address: ……………………………………………….……………

Phone No: ……………………………………………….……………

Specialist: …..……………………………………..………………..

Address: ……………………………………………….……………

Phone No: ……………………………………………….……………..

Specialist: …..……………………………………..………………..

Address: ……………………………………………….……………..

Phone No: ……………………………………………….……………..

Specialist: …..……………………………………..………………..

Address: ……………………………………………….……………..

Phone No: ……………………………………………….……………..

Other: ………..…………………………………………..…………..

Address: ……………………………………………….……………

Phone No: ……………………………………………….……………

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Known Health History:
(*This must be completed by GP/Specialist)*

Diagnoses:

Medications:

Allergies:

Personal History:
(*e.g. Enuresis)*

Immunisations:

General Health:

Doctor:

Signature: ______________________________ **Date:** ____________________