TE WHAITIPU COUNSELLING
(previously known as Mid North Family Support)
09 407 7511
info@tewhaitipu.co.nz
www.tewhaitipu.co.nz

CHILD / YOUNG PERSON – Client Referral Form

1. REFERRER DETAILS			
Referral Date:			
Referral Agency:			
Referrer Name:			
Position/Relationship:			
Phone:		**Email:**	
2. CHILD / YOUNG PERSON DETAILS			
Do both parents give consent to this referral?		**Yes** ☐	**No** ☐
Does client also give consent to their Ethnicity, Age and Gender only, being used for statistical reporting purposes? **(No other personal data will be used or shared)**		**Yes** ☐	**No** ☐
Full Name:			
Gender / Pronoun:		**Date of Birth:**	
Phone:		**Email:**	
Physical Address:			
Ethnicity:		**Birth Country:**	
Hapu:		**Iwi:**	
Parent/caregiver 1:		**Relationship to client:**	
Contact Phone:		**Address:**	
Email:			
Parent/caregiver 2:		**Relationship to client:**	
Contact Phone:		**Address:**	
Email:			
Secondary Contact:	Name:		
	Phone:		
	Relationship:		
Are there any cultural requests we can provide for the Child / Young Person?		**Yes** ☐	**No** ☐

3. REASON/S FOR REFERRAL		
What is the main reason for enrolling Child / Young Person with Te Whaitipu Counselling?		
Are there any parenting or court orders? (Please attach copies)	**Yes** ☐	**No** ☐
Is the Child / Young Person a survivor of sexual harm?	**Yes** ☐	**No** ☐
Has the Child / Young Person experienced family violence?	**Yes** ☐	**No** ☐
Are there any specific needs to be considered? (e.g Stairs a problem?)	**Yes** ☐	**No** ☐
Is there any further information (e.g mental or physical health diagnosis?)	**Yes** ☐	**No** ☐
What supports are currently in place?		
Name of Agency	Contact name and details	

PLEASE SEND YOUR REFERRAL TO: info@tewhaitipu.co.nz

THANK YOU 😊