# BWT Referral Form

*Please note that this for is for non-urgent referrals, for anything urgent please ring the crisis line on 0800 Refuge.*

*Please ensure that all information on the form is collected. Email to* [*referrals@bwt.org.nz*](mailto:referrals@bwt.org.nz)

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| **Referrer Details:** |

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| Referrer: | Self o | Police o | | Othero\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Do you require a Kaupapa Māori Service? | | | YES NO |  |
| **Referrer Name** | | |  | | | **Referrer’s Phone** |  | | |
| **Referrer’s Email** | | |  | | | **Date Referral Sent:** |  | | |
| **Has client consented to referral?** | | | **Yes 🞏** | | | **No 🞏**  Please ensure client has consented before proceeding with referral | | | |

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| **Client information** |

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| **Full Name** |  | | | **Gender** |  | |
| **Date of Birth** |  | | | **Are they safe right now?** | **Yes 🞏** | **No 🞏**  Please call 111 or the crisis line (0800 Refuge) |
| **Known by any other names?** |  | | |
| **Address** |  | | | | | |
| **Phone** |  | | | **Email** |  | |
| **Is it safe to text or call?** | | **Yes 🞏** | **No 🞏** | **Comment:** | | |
| **Ethnicity (iwi)** |  | | | **Do they have transport?** | **Yes 🞏** | **No 🞏** |
| **Emergency Contact:**  *(Name, relationship and phone number)* |  | | | | | |
| **Accommodation Situation:** | **Renting 🞏 Kainga Ora 🞏 Own Home 🞏 Family/Friends 🞏 No Fixed Abode 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |

**Children information**

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| **Perpetrator information** |

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| **Perpetrators Name:** |  | | **Date of Birth:** | |  | |
| **Relationship to Client:** |  | | | | | |
| **Address (if known):** |  | | | | | |
| **Protection Order** | **Yes 🞏** | **No 🞏** | **With Notice 🞏** | **Without Notice 🞏** | | |
| **Breached** | **Yes 🞏** | **No 🞏** | **Parenting Order** | **Yes 🞏** | | **No 🞏** |
| **Drug or Alcohol?**  **Gang connections?**  *Details* |  | | **Have there been previous police involvement?** | **Yes 🞏** | | **No 🞏** |

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| **Children information** |

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| **Name:** | **Ethnicity** | **Age** | **M / F** | **Who do they live with?** |
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| **Health Information:** |

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| **Any Physical or Mental Health Concerns for client or children?** *Health conditions, disabilities, diagnosis* |  |
| **Any prescribed medication?** *Details (names and dosage)* |  |
| **Any self-harm/suicidal Ideation:**  ***How recent? When was the last incident?*** |  |
| **Do you use drugs or alcohol?** *What kind, how often, most recent use?* |  |

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| **Additional Information:** |

*Reason for Referral:*

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Are there any other agencies involved with the family? **Yes 🞏 No 🞏**

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| **For Office Use:** |

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| Entered onto Recordbase |  |
| Referral Attached |  |
| Entered onto spreadsheet |  |
| Worker Allocated: |  |

**Assessment of Services Required:**

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| Community 🞏 | Residential 🞏 | DV ED 🞏 | Counselling 🞏 | Advice Given 🞏 | No Further Action 🞏 |