Please complete the below referral form by filling in the blue brackets.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Referral [Date] | | | Service Required: [] | | | | | | | | | | Urgent: [] | | | |
| Main reason for Referral  [] | | | | | | | | | | | | | | | | |
| **YOUNG PERSONS INFORMATION** | | | | | | | | | | | | | | | | |
| Last name  [Last Name] | | | | | First name/s  [First Name] | | | | | | | Preferred name  [Preferred Name] | | | | |
| Ethnicity  [Ethnicity] | | | | Iwi/Hapū  [] | | | | | | Date of birth  [] | | | | Age  [] | | Gender  [] |
| [Cultural information you would like us to know] | | | | | | | | | | | | | | | | |
| Home phone  [Phone] | | Mobile phone  [Phone] | | | | | | | | Email  [Email] | | | | | | |
| Address  [Address] | | | | | | | | | | | | | | | | |
| School/training provider/work  [] | | | | | | | Study/work details  [] | | | | | | | | | |
| Significant health/safety Concern  [] | | | | | | | General Practitioner  [Name] [Phone] | | | | | | | | | |
| Young person’s understanding of referral to Challenge 2000  [What does the young person know about Challenge2000? Does the young person want to engage with the service?] | | | | | | | | | | | | | | | | |
| **WHĀNAU AND SOCIAL NETWORK** | | | | | | | | | | | | | | | | |
| Name of key person  [Example;Parent/Caregiver/Spouse/Partner/Close Friend] | | | | | | | | Relationship to Young Person  [Relationship] | | | | | | | | |
| Home phone  [Phone] | | | Mobile phone  [Phone] | | | | | | | | Email  [Email] | | | | | |
| Address  [Address] | | | | | | | | | | | | | | | | |
| Name of key person  [Example;Parent/Caregiver/Spouse/Partner/Close Friend] | | | | | | | | Relationship to Young Person  [Relationship] | | | | | | | | |
| Home phone  [Phone] | | | Mobile phone  [Phone] | | | | | | | | Home phone  [Phone] | | | | | |
| Address  [Address] | | | | | | | | | | | | | | | | |
| Name of key person  [Example;Parent/Caregiver/Spouse/Partner/Close Friend] | | | | | | | | Relationship to Young Person  [Relationship] | | | | | | | | |
| Home phone  [Phone] | | | Mobile phone  [Phone] | | | | | | | | Home phone  [Phone] | | | | | |
| Address  [Address] | | | | | | | | | | | | | | | | |
| **SIBLINGS/CHILDREN LIVING WITH YOUNG PERSON** | | | | | | | | | | | | | | | | |
| Name | | | Age | | | | | | | | Relevant Information | | | | | |
|  | | |  | | | | | | | |  | | | | | |
|  | | |  | | | | | | | |  | | | | | |
|  | | |  | | | | | | | |  | | | | | |
|  | | |  | | | | | | | |  | | | | | |
| Legal Guardian (if applicable) [] | | | | | | | | | | | | | | | | |
| **AGENCIES AND COMMUNITY SUPPORTS** | | | | | | | | | | | | | | | | |
| Name of agency  (Example; CYFS, Legal agencies, advocates ) | Key Person | | | | | | | | Phone Number | | | | | | Email Address | |
|  |  | | | | | | | |  | | | | | |  | |
|  |  | | | | | | | |  | | | | | |  | |
|  |  | | | | | | | |  | | | | | |  | |
|  |  | | | | | | | |  | | | | | |  | |
|  |  | | | | | | | |  | | | | | |  | |
| **CURRENT HEALTH AND WELL-BEING** | | | | | | | | | | | | | | | | |
| **Taha Tinana (physical well-being)**  The physical health of the young person. For example; their ability to care for their body (drug use, diet, grooming etc.). Physical strengths or limitations.  [Comment] | | | | | | | | **Taha Wairua (spiritual well-being)**  Does this young person appear to have found purpose and meaning in their lives or do they need more support in this journey?  [Comment] | | | | | | | | |
| **Taha Whānau (Social well-being)**  Does this young person have a sense of belonging? Do they belong to community groups or have close friendships? Do they need support to build healthy relationships and community?  [Comment] | | | | | | | | **Taha Hinengaro: (Mental and emotional well-being)**  Is this young person able to understand and explore their emotions/feelings? How do they manage anger, sadness, excitement etc.? Are there any mental health concerns?  [Comment] | | | | | | | | |
| What would you like the outcome of Challenge 2000 support to be?  [] | | | | | | | | | | | | | | | | |
| **REFERRERS DETAILS** | | | | | | | | | | | | | | | | |
| Name  [Name] | | | Agency (if applicable)  [] | | | | | | | | Contact Details  [Phone]  [Email] | | | | | |
| **ADMINISTRATION USE ONLY Date referral received** [Date] | | | | | | | | | | | | | | | | |
| Dates | | | | | | Follow-up | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | |
| Outcome [Select] | | | | | | Contract [Select] | | | | | | | | | | |