

RIGHT SERVICE RIGHT TIME



**Social Service Providers
Aotearoa Inc.**

SSPA

Children, Family, Community

AGENCY REQUEST FOR SERVICE

To: Right Service Right Time Coordinator

Date: _____

Referred by:

Agency: _____ DDI: _____

Referrer Name: _____ email: _____

CONSENT: The family/whānau has consented to this referral and we have attached, posted or faxed the signed consent form available on the RSRT website.

Family/Whānau Details:

Parent One Name: _____ DOB: _____

Ethnicity: _____ Iwi: _____

Language spoken: _____ Is a professional interpreter needed? Yes No

Address: _____

Telephone: _____ email: _____

Parent Two Name: _____ DOB: _____

Ethnicity: _____ Iwi: _____

Language spoken: _____ Is a professional interpreter needed? Yes No

Address: _____

Telephone: _____ email: _____

Caregiver: _____ DOB: _____

Ethnicity: _____ Iwi: _____

Language spoken: _____ Is a professional interpreter needed? Yes No

Address: _____

Telephone: _____ email: _____

Children's Details (may include 'unborn').

Child's Name	Gender	Date of Birth	School/Preschool Name	Ethnicity	Resides at Home
	M <input type="radio"/> F <input type="radio"/>				<input type="radio"/>
	M <input type="radio"/> F <input type="radio"/>				<input type="radio"/>
	M <input type="radio"/> F <input type="radio"/>				<input type="radio"/>
	M <input type="radio"/> F <input type="radio"/>				<input type="radio"/>
	M <input type="radio"/> F <input type="radio"/>				<input type="radio"/>
	M <input type="radio"/> F <input type="radio"/>				<input type="radio"/>

A PRELIMINARY ASSESSMENT HAS BEEN UNDERTAKEN AND THE IDENTIFIED ISSUES/MAIN REASONS FOR THIS REFERRAL ARE:

Family/whānau needs/key issues:

Strengths/resources/supports within family/whānau:

Previous Interventions: (if any)

_____ Agency: _____

_____ Agency: _____

Immediate safety issues for community agency caseworker: (if any)

Legal status with Oranga Tamariki, Ministry for Children: (if any)

Relevant custody/access arrangements: (if any)

Do you have any suggestions regarding the type of service the family/whānau requires:

Current status with Oranga Tamariki, Ministry for Children: (if any)

GP/Primary Health Provider name and contact details:

Any other relevant information:

Including any internal & external reports that have been completed eg: Suicide Risk, Child Abuse, Psychometric or DSM IV Assessment.

OTHER SERVICES / PROFESSIONALS CURRENTLY INVOLVED WITH FAMILY/WHĀNAU:

Name	Agency	Role	Phone

FAMILY/WHĀNAU SUPPORT NETWORK: Other family and important significant others (including grandparents, carers, neighbours, extended family).

Name	Gender	Relationship	Contact Details	Resides at Home
	M <input type="radio"/> F <input type="radio"/>			<input type="radio"/>
	M <input type="radio"/> F <input type="radio"/>			<input type="radio"/>
	M <input type="radio"/> F <input type="radio"/>			<input type="radio"/>

SUMMARY OF FAMILY/WHĀNAU HISTORY:

Referrer Name/ Designation: _____

Signature (if form is posted): _____

Date: _____

Thank you for contacting Right Service Right Time, our coordinator will contact you within 2 weeks of receiving this form.

print finished form

save a copy of the form

RIGHT SERVICE RIGHT TIME



CONSENT FORM

To: **Right Service Right Time Coordinator**

Date: _____

I _____ (Client Name)

give consent for Right Service Right Time to consult with relevant agencies to inform and progress this Referral for Services.

I understand that the information will be confidential and used by the Right Service Right Time service pursuant to the Privacy Act 1993, and kept appropriately confidential.

I understand that if the Right Service Right Time service identifies that there are safety issues for me and/or others, it will, if possible, discuss the concerns with me before releasing information to the Police and/or Oranga Tamariki .

I understand that the following agencies may be represented on a RSRT Response Panel when my information is discussed. The Response Panel includes, but is not limited to, staff from the following organisations:

Barnardos NZ

START

Hauora Trust

CDHB Mental Health

Christchurch Methodist Mission

Purapura Whetu

Oranga Tamariki, Ministry for Children

Presbyterian Support Family Works

Te Whare Whero

Early Start

Name of GP/Medical Centre: _____

Do you consent to Right Service Right Time informing your GP of the outcome of this referral? Yes/No

I am aware that I can withdraw from this process at any stage.

Client Signature: _____ Date: _____