Te Aho Tapu Trust
Psychological Services

REFERRAL FORM

Name: _____ Date of Birth: _____

Ethnicity: _____ Iwi Affiliation: _____

Address: _____ Phone: _____

_____ M/F/Other _____

Caregiver/Parent _____

Whanau (Children/adults living in home)

Name	**Age**	**Relationship** e.g Mother, sibling, Aunty	Living at home? Yes/No

Therapeutic Intervention: (please tick)

- ☐ Family Violence Prevention Programme for Women with vulnerable dependent children
- ☐ Children who have witnessed violence
- ☐ Youth 'at risk' of offending programme
- ☐ Consultation (Papakura Office only)

Massey Homestead
351 Massey Rd
Mangere East
MANUKAU 2024

Te Aho Tapu Trust
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Hunters Corner
Manukau 2155

Phone: (09) 275 5610
Fax: (09) 275 8034
info@teahotapu.com
www.teahotapu.com

Referral Information/Presenting Issues:

Agencies involved with whanau/client:

Agency Name	Contact	Role

CONSENT – This section must be completed

Name of person giving consent: ……

Role: ☐ Parent ☐ Guardian ☐ Caregiver ☐ Social Worker ☐ Self

I, …… *(print name)* give my consent for Te Aho Tapu Trust to collect and release information pertaining to ……. *(client name)* that is relevant to the assessment and/or therapeutic process.

In giving this consent I understand that:
Information about my own, or my child's/or this client's circumstances may be forwarded to Te Aho Tapu Trust for assessment and/or therapeutic intervention.

And/or

- Information about my own or my child/this client's circumstances may be shared with other agencies relevant to the therapeutic assessment/intervention
- The information may be audited by MSD to ensure appropriate service delivery
- I agree that I and/or my child/this client will work with Te Aho Tapu Trust and its staff.

I understand and agree to the above statements.

Signature: …… Date: …….

Supporting Information:

Referrer's Details

Referrer: ..... Agency: .....

Phone: ..... Email: .....

Signature: ..... Date: .....