CLIENT INFORMATION FORM YOUNG PERSON

Date Received by START: ____________________ (Office Use Only).

Please complete both sides as much as you can. This information is required to process your referral and may be used in a non-identifiable way by START for statistical purposes.

Full Name: ....

Address: ....

Telephone: ....(home) ....(work/cell)

Emergency Contact: Name .... Relationship ....
Address .... Ph: ....

Date of Birth: .... Age: ....

Ethnicity: .... Male/Female
(for statistical purposes only, if Maori please state tribal affiliation) (Please circle)

Current Living Arrangements: (Please give names and ages (where appropriate) of all other people who live at this address, including who they are in relation to the young person- e.g. mother, sibling, boarder)
....
....
....

If not mentioned above please note:
Mother's Name and Address:
....
Father's Name and Address:
....

If appropriate, please describe the current custody and access arrangements
....

Do you have a Protection Order in place regarding -Yourself? YES / NO
-Your children YES / NO
If yes who is the person you/ they are protected from.
....

Are there any persons of concern to you that we need to know about?
…………………………………………………………………………………………………
…………………………………………………………………………………………………

GP's name and contact details……………………………………………………………
Consent to contact GP if appropriate **Yes/No**

Relationship of Abuser:……………………………………

Statutory Body Disclosed To: (Please indicate Police or CYFS and location of office).
……………………………………………………………………………………………………
Has an Evidential Interview been completed? **Yes/No**
Consent to obtain a copy of this **Yes/No**
(Note: this consent is required for START to proceed with the referral)

Has a Medical Examination been Carried Out? **Yes/No**

Has the abuser been prosecuted, or are there plans to do so? **Yes/No**
Details:…………………………………………………………………………………………
……………………………………………………………………………………………………

Is the abuser involved in the STOP Programme?………………………………………

Previous contact with START regarding this young person: (Please supply date)……………

☐ Counselling ☐ Consultation ☐ Phone

Where did you hear about START's services?…………………………………………………

Previous counselling history elsewhere:

……………………………………………………………………………………………………

Has the young person previously had an ACC Sensitive Claim **Yes/No**
Details(including ACC claim Number if known):
……………………………………………………………………………………………………
……………………………………………………………………………………………………

If the referred young person has had contact with ACC, do you give consent for START to contact ACC regarding the claim history to aid the referral process?
Yes/No

What Difficulties Relating to the Abuse is the Young Person Currently Experiencing?..
....
....

Any Other Relevant History or Information:
....
....
....

START expects a parent/caregiver to be actively involved with the young person's counselling. Who will this person be and what is their relationship to the young person?
....

Please indicate days/times you would be **unable** to attend counselling? Please note that restricted availability for appointments may result in a longer waiting period.
....

Do you want to receive text reminders for your appointments: **Yes/No**

Is it ok to leave telephone messages for you? **Yes / No**

Are any of the following services involved (currently or in the past) with the referred young person?

		Consent to contact
Child Youth and Family (CYFs)	**Yes/No**	**Yes/No**
Mental Health Services	**Yes/No**	**Yes/No**
Other social services	**Yes/No**	**Yes/N**

Form information filled in by: **Name:** ....

Date : ....

Client or Caregiver (If child is under 17 years)

Consent to obtain information

Signature: ....