CLIENT INFORMATION FORM
CHILDREN & YOUNG PEOPLE

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:……………………………… Gender……………………………

Ethnicity/ies: ……………………………………………………………………………………………
(for statistical purposes only, if Maori please state tribal affiliation)

Who else lives in the home?: (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?

………

GP's name and contact details……………………………………………………………

What is the child/young person's relationship to the person who sexually harmed them? (ie specific family member, stranger etc)
………

Statutory Body Disclosed To: (Please indicate Police or Oranga Tamariki).
………
Has an Evidential Interview been completed? **Yes/No**

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

Has the person who has acted in a sexually harmful way been prosecuted, or are there plans for the Police to do so? **Yes/No**
Details:…………………………………………………………………………………………………

Is the person who has acted in a sexually harmful way involved in the STOP Programme?……………………………………………………………………………………

Previous contact with START regarding this young person:

☐ Counselling ☐ Consultation ☐ Phone

Previous counselling history elsewhere:

……………………………………………………………………………………………

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

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 supporting the child's/young person's counselling. Who will this person be and what is their relationship to the child/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**

Where did you hear about START?

If any of the following services are involved (currently or in the past) with the referred child/young person, please circle below to allow START to contact them if appropriate

Child/Young Person's name……………………………Consent to contact

1.Consent to obtain copy of Evidential Interview………………………**Yes/No**
(note: disclosure must be evidenced for referral to proceed)
2. Consent for START to contact Stop………………………………………**Yes/No**
3. Consent to contact GP…………………………………………………………**Yes/No**
4. Consent to contact other Social Services………………………………**Yes/No**
5. Consent to contact ACC regarding claim number/history………..**Yes/No**
6. Consent to contact Oranga Tamariki……………………………………**Yes/No**
7. Consent to contact Mental Health Services……………………………**Yes/No**

Form information filled in by:

Name:………………………………………………..
Contact Number………………………………
Email…………………………………………………
Date…………………………………………………..

Guardian / Parental Signature (required)…………………………………………………….

Child's Signature (where appropriate)……………………………………………………