

***“A safe, crime-free Kapiti”***

**Family Support Services**

**Referral Form**

Child’s Name:**…………………………………………………**  D.O.B: **……………**

Gender: F M (please circle) Age: **……** years **…….** (months)

Ethnicity: **………………………………**  Iwi: **…………………………..**

Address: **……………………………………………………………………………………………..**

Parent/Guardian Name/s: (1) **……………………………..** (2)**………………………………**

Parent/Guardian (1) Daytime contact no:**………………………**Mobile:**…………………..**

Parent/Guardian (2) Daytime contact no:**………………………**Mobile:**……………………**

School:**…………………………**Year/Class**…………………**Teacher:**……………………………**

Concerns leading to this referral:

* ………………………………………………………………………………………
* ………………………………………………………………………………………
* ………………………………………………………………………………………

Have these concerns been discussed with the whanau/family? Yes / No

Is the whanau/family aware this referral has been made? Yes / No

Are any other agencies involved? Yes / No

If yes please list agencies and contact person if known

**\* If there is any immediate danger to the child or care and protection issues, contact The Ministry of Children ( 0508 326 459 ) or the Police 111.**

Referrer name**…………………………………** Position: **………………………………**

Contact Phone: **……………………………….** Email **……………………………………**

Signed:**………………………………………………………..** Date: **………………………**