Catholic Family Support Services
Keeping Hope Alive

Referral Date	

100 Morrinsville Road PO Box 24010, Hamilton 3253
Telephone: (07) 856-3760
Email: john@cfss.org.nz

Referral for Service Units

Has the family consented to the support being requested?	Yes	No

Type of Service required Tick service required (✓)

Intensive Family Support		**For Supervised Contact -please use Supervised contact form**
Support to achieve FGC Plan		

Family details (i.e Parent/Caregiver,)

Name:			
Address:			
Ethnicity:		Iwi:	
Date of Birth:		Marital Status:	
Home Number:		Mobile Number:	

Partner (if applicable)

Name	**Ethnicity**	**Date of Birth**	**Age**	**Gender**

Phone:	Mobile	Address

Child/Children or name of young person for mentoring referrals

Name(s)	**Ethnicity**	**Date of Birth**	**Age**	**Gender**

Background reasons for referral:	
(Please continue on additional page if necessary)	

Level of Risk (please continue on back page)	**High** **Medium** **Low** (Please circle)
Risk to staff including: Risks at the home (e.g. gang affiliation, dogs on property), drug and alcohol usage, Mental Health concerns, History of violence and risks to the child	

Other Agencies Involved:	

Outcomes expected:	

Please allow for travel time to and from the clients home when allocating hours to clients – we would also request that you consider additional hours for administration time (for writing up of case notes/attending meetings etc).

Number of visits per week:	
Number of hours per visit:	
How many visits requested:	
Total hours requested (including travel/admin):	

Review date:	

Referred by:		**Phone/Mobile:**	
Oranga Tamariki site			
Approved by Supervisor:		**Date:**	
Authorised by Site Manager:		**Date:**	

CFSS Use only:

Date referral received by CFSS:		**CFSS Client Number:**
Date entered on to Database:		