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| Referral Date | |
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100 Morrinsville Road PO Box 24010, Hamilton 3253
 Telephone/Fax: (07) 856-3760
 Email: katrina@cfss.org.nz

Referral for Supervised Contact

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|---------------------------------|----------------------|----------------------|------------------------|----------------------|
| Method of Payment (please tick) | Service Units | <input type="text"/> | Fee for Service | <input type="text"/> |
|---------------------------------|----------------------|----------------------|------------------------|----------------------|

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| Has the family consented to being referred for supervised contact? | <input type="text" value="Yes"/> | <input type="text" value="No"/> |
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| How long has Oranga Tamariki been involved: | |
| Name of Council for Child: | Contact number for C4C: |
| What if any criminal charges are pending: | |
| Court Orders: please attach any orders | |
| Does plan for child include return to parent's care | |

Name of Parent(s) to have supervised contact

| Parent 1 | | | | Parent 2 | | | |
|-----------------|--|------|--|-----------------|--|------|--|
| Name: | | | | | | | |
| Address: | | | | | | | |
| | | | | | | | |
| Ethnicity: | | Iwi: | | Ethnicity: | | Iwi: | |
| Date of Birth: | | | | Date of Birth: | | | |
| Home Phone: | | | | Home Phone: | | | |
| Mobile Phone: | | | | Mobile Phone: | | | |
| Marital Status: | | | | Marital Status: | | | |

Caregiver

| | | | |
|-------------|--|---------|--|
| Name | | | |
| Phone: | | Mobile: | |
| Address: | | | |

Child/Children to have supervised contact

| Name(s) | Ethnicity | Date of Birth | Age | Gender |
|---------|-----------|---------------|-----|--------|
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Names of additional approved visitors

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Other Agencies Involved

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Outcomes expected

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| How many visits requested: | |
| Number of hours per visit (every hour of contact is worth two service units): | |
| Frequency of contact: | |
| Assessment time with visiting parent(s), caregiver and children (3-4 hours) | |
| Admin time @15 minutes per session | |
| Total service units requested (including assessment/ admin): | |

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| Review date: | |
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| Referred by: | | Phone/Mobile: | |
| Oranga Tamariki Site: | | | |
| Approved by Supervisor: | | Date: | |
| Authorised by Site Manager: | | Date: | |

CFSS Use only:

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