

# Kaiwhakatere Navigator™ Programme

## Adult Services Referral Form

For adults 18 years and over who have not engaged in any harmful sexual behaviour towards children or young people but are concerned or distressed about their sexualised thoughts.

- Please answer all relevant questions. Note: Fields marked \* are mandatory.
- If information is unavailable or a question is **not** applicable, please indicate this.
- Incomplete referral forms cannot be processed and will be returned to the referrer.
- Referrals can be sent to: PO Box 8726, Newmarket, Auckland 1150 Faxed to 09 377 9229

Email: info@safenetwork.org.nz

PERSON BEING REFERRED			
Name of person being referred*			
Occupation			
Date of birth*:	Male	Female	Gender-diverse
Ethnicity			
lwi / Hapu (if NZ Maori)			
Street Address*			
Suburb			
Town/City*			
Postcode*			
Primary phone number*			
Home phone number			
Work phone number			
Mobile phone number			
Email			

										- 4		
к	-	-	-	ĸ	ĸ	-	ĸ	1)	-	IΔ	١Ш	LS

REFERRER DETAILS	
Referrer name*	
Phone number*	
Email*	
If referred by Agency /Community Orga	anisation
Position	
Organisation name	
Address	
Work phone number	
Mobile phone number	
If referred by Relative or Other	
Relationship to person referred	
Address	
Home phone number	
Mobile phone number	
REASON FOR REFERRAL  Please provide a brief description of the s referred, and its impacts on their wellbeing	exualised thoughts causing concern or distress for the person $g^{\star}.$

	Yes	No	Unknown
Has the person being referred ever been the victim of sexual abuse? *			
Has the person being referred ever lodged an Integrated Sensitive			
Claims application (ISCC) with ACC? *			

Name	
Relationship to person referred	
Address	
Home phone number	
Work phone number	
Mobile phone number	
Email	
Name	
Relationship to person referred	
Address	
Home phone number	
Work phone number	
Mobile phone number	
Email	
Name	
Relationship to person referred	
Address	
Home phone number	
Work phone number	
Mobile phone number	
Email	

SUPPORT		
	en taken to address the needs of the person referm	red if known*
riedse indicate what other steps have bee	en taken to address the needs of the person referr	eu, ii kilowii .
Please provide the names of any counsell supporting the person referred, if known.	lors and/or social workers who have been involved	with
Name		
Contact details		
Name		
Contact details		
OTHER AGENCY INVOLVEMENT (if Describe current or past history of any other		

Please include with the referral any document or reports relating to other agency involvement.

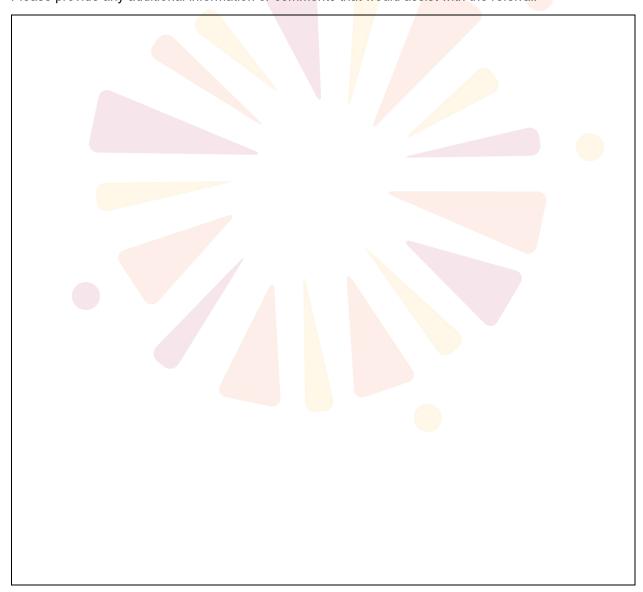
### **REPORTS**

Please include the following reports with the referral, where available.

Report	Included	Written by	Date
Psychological Reports			
Neuropsychological Reports			
Educational Reports			
Psychiatric Reports			
Medical Reports			

## OTHER COMMENTS OR ADDITIONAL INFORMATION

Please provide any additional information or comments that would assist with the referral.



#### **COMPLETION CHECKLIST**

Before sending, please check the following.

All sections and mandatory fields have been completed*.	
All reports and documents have been included.	

#### **CONFIRMATION**

The person being referred agrees to this referral being made*.	
The information provided is correct to the best of the knowledge of the person making the referral*.	
Date of referral*	

Safe Network will store all personal information collected in a client management database managed by Trinity Alliance, a grouping of three agencies providing similar services: Safe Network, WellStop and Stop.

Personal information stored in the Trinity Alliance client management database may be accessible to the other agencies within Trinity Alliance.

All Trinity Alliance agencies will respect the confidential nature of a client's personal information.