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	
Iwi / Hapu (if NZ Maori)	

Street Address*	
Suburb	
Town/City*	
Postcode*	
Primary phone number*	
Home phone number	
Work phone number	
Mobile phone number	
Email	

REFERRER DETAILS

Referrer name*	
Phone number*	
Email*	

If referred by Agency /Community Organisation

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 sexualised thoughts causing concern or distress for the person referred, and its impacts on their wellbeing*.

	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? *	☐	☐	☐

SUPPORT PEOPLE AND FAMILY CONTACT DETAILS

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

Please indicate what other steps have been taken to address the needs of the person referred, if known*.

Please provide the names of any counsellors and/or social workers who have been involved with supporting the person referred, if known.

Name	
Contact details	
Name	
Contact details	

OTHER AGENCY INVOLVEMENT (if any)

Describe current or past history of any other agency involvement, if any*.

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.