Service Intake/ Self-Referral Form



Date:			Have you acc	essed our service before	e? Yes/No
Title: Name:				Preferred name:	
Date of Birth:	Ag	e:	Gender: M	F Other	
				e living in the Cambrid you live outside of our	
Address: Can we send mail to this a					
Telephone:			Mobile:		
Can we leave a message of				ou on this number?	Yes/No
Please indicate your res	sidency status:		-	with Audio Visual (eg.Z	
NZ Citizen	NZ Resident	Other	(if other please exp	olain)	
Country you were you I Your Ethnicity (Tick as m					
NZ Maori	🗖 Iwi				
NZ Pakeha/European					
Pacific	(Please spe	cify)			
Asian	🔲 (Please spe	cify)			
European	(Please spe)	cify)			
Other Ethnicity	🔲 (Please Spe	cify)			
Next of Kin: Name			Phone/e	email	
Is there an alternative p Yes/No	person we can con	tact on your b	ehalf or in case c	of an emergency (if diffe	erent from above)
	Relatio	onship:		Phone no:	
Who referred you to ou (E.g. Doctor, Friend, Fam					
Current Doctor:		Lc	ocation:		
Do you have any allerg	ies or medical aler	ts? Yes/No:			
Do you have any specif	ic support needs?	E.g. hearing, vi	isual, mobility, liter	racy, other?	Yes/No
If yes, please explain					
Do you hold a current (Community Servic	es Card? Yes/	No Card No:		
Are you currently enrolled with another agency or service? Yes/No:					
(E.g. CADS, Mental Healt	h, ICAMHs, Financia	al/budget, Orar	 nga Tamariki, Prob	ation, Diversion, Employn	nent support i.e Workwise)

Counselling sessions are charged at a subsidised rate of \$60 per session – Adult, \$30 – Youth, Community Services Card - \$40

Will you be able to meet this cost? (does not apply to Alcohol & Drug, Family Violence, GP funded) Yes/No

Do you have any children under the age of 18? If so, please give details below:

Name	Date of birth	Do they live with you?
		Yes/No

Please indicate which best describes your reasons for contacting us					
Tick as many as applicable then place a star next to the most pressing reason *					
Information or support		Health			
Money / Finances		Alcohol and/or Drug			
Family		Anxiety			
Relationship		Depression			
Stress		Anger			
Grief / Loss		Violence or Abuse			
Literacy (reading/writing)		Other			

In completing this form you are requesting assistance from our agency. For our records we will add your details to our internal database for statistical purposes and to contact you for an appointment.

We look forward to offering you an appointment as soon as possible. Should you need to cancel your appointment please give us as much notice as you can. If you miss repeated appointment's we may need to close your referral.

We reserve the right to turn away people who are abusive toward staff, or others at our services or appear to be unduly under the influence of alcohol or drugs at the time of their appointment.

FOR STAFF USE ONLY						
Services Required:						
Staff Member/s:			Contract:			
Payment Options Discussed:		Agreed Payment Amount: \$per session				
Allocation: U	rgent 🗆	Semi Urgent 🛛	Non Urgent 🛛			
Added to Recordbase		1 st Appo	intment Date:			