Christchurch Resettlement Services

Referral

PLEASE COMPLETE EACH FIELD

OFFICE USE ONLY

Engagement ID: _____
Status: _____
NHI: _____
WL Letter: _____
Date allocated: _____
S/Work / Counsel: _____
Appt. Letter: _____
1st Contact: _____
Closed: _____

DATE: _____

CLIENT NAME: _____

GENDER: _____

ADDRESS: _____

_____

_____

PHONE: _____

DOB: _____

ETHNICITY: _____

LANGUAGE SPOKEN: _____

IS AN INTERPRETER NEEDED? Yes

COUNTRY OF BIRTH: _____

IMMIGRATION STATUS: _____

TIME IN NEW ZEALAND: _____

G.P. _____

REFERRED BY: _____

SERVICE: _____

POSTAL ADDRESS: _____

_____

_____

PHONE NO: _____

EMAIL ADDRESS: _____

1. Service requested: Social Work Counselling

2. Reason for referral:

3. Additional information:

4. Referrers / Client expectation:

5. Risk:

6. Client Emergency Contact: Name: _____ Phone: _____

Has the client been to CRS before?

When? (If Known) _____

Is this Urgent? Yes

Client Referral Consent: Yes

Please send this referral form to: Clinical Social Work Leader, CRS, PO Box 9062, Christchurch 8149

To discuss this referral form, email Clinical Social Work Leader at admin@crs.org.nz