***BEACON* AOTEAROA**

**PROGRAMME & SERVICE REFERRAL FORM**

**REFERRED CLIENT INFORMATION**

|  |  |
| --- | --- |
| **First name:** |  |
| **Last name:** |  |
| **DOB:** | **Age: yrs** |
| **Male[M] or Female [F]:** |  |
| **Family agreed to referral? [if applicable]** | **YES / NO** |
| **Primary Caregiver’s name:** |  |
| **Their relationship to the referred client:** |  |
| **Address of person being referred:** | |
|  | |
|  | |
|  | |
| **How can we contact the individual or their caregiver during office hours?** | |
| Name: | |
| Phone: | |
| Mobile: | |
| E-mail: | |
| **What do we need to know about the individual, caregiver, or organisation being referred to be able to best meet their needs and the reason for referral?** | |
| **[START TYPING NEXT TO ASTERIX]: \*** | |

**Who is being referred?** **[put a line through those that do not apply]**

* **An individual who meets the referral criteria**
* **A parent/caregiver of someone with meets the referral criteria**
* **An organisation who supports someone who meets the referral criteria**

**Referrer’s Details:**

|  |  |
| --- | --- |
| **Name:** |  |
| **Designation:** |  |
| **Organisation:** |  |
| **Phone:** |  |
| **E-mail:** |  |
| **Address:** |  |
|  |

***Signature:***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

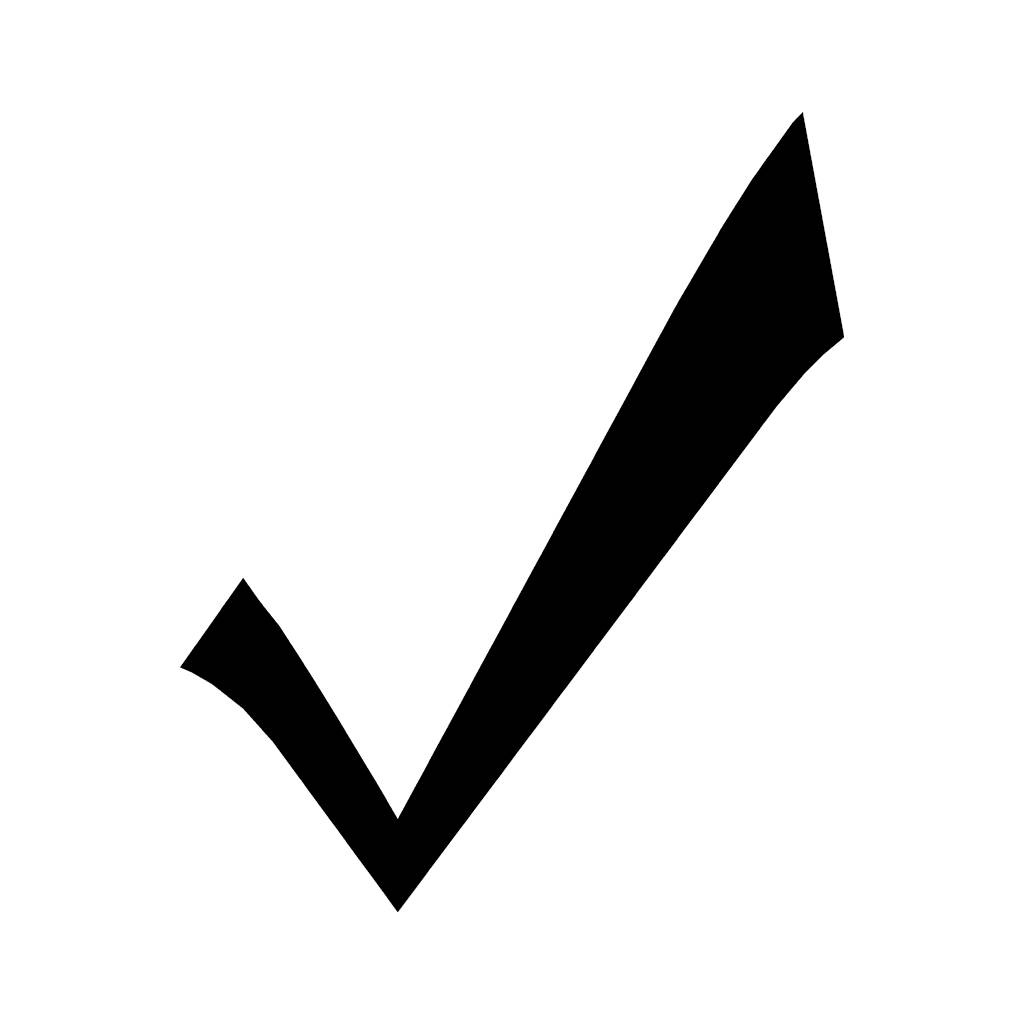
**FOR OFFICE USE ONLY:**

**Date received**:

**Lead Partner assigned:**

|  |
| --- |
|  |

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| --- |
| **PLEASE WRITE DOWN THE KEY REASONS & OBJECTIVES FOR THE REFERRAL: [Attach more information to the Referral Form if required]** |
| **[START TYPING NEXT TO ASTERIX]: \*** |

**Please put a tick  by the BEACON Programme[s] you want delivered to the referred client:**

|  |  |
| --- | --- |
| **BEGIN Programme**  **Baby Early Gains Intervention *[0-3 years]*** |  |
| **BOSS Programme**  **Boss of Your Bladder *[8 years & over]*** |  |
| **Diagnostic Service** |  |
| **EMoTE Programme [Whakahaere i Kare]**  ***[5 years & over]*** |  |
| **FAMES Programme [Pūtea Pūkenga] *for* financial management skills *[15 years & over]*** |  |
| **Guardian Angel In-Home Parenting & Caregiving Support Programme** |  |
| **Group Parenting & Caregiving Support Prog** |  |
| **iDEPT Independence Programme** |  |
| **ISP Programme [Individualized Strategies Plans]** |  |
| **KEY Programme**  **Key Worker Support *for* parents/caregivers** |  |
| **Kia kaha Programme *for* resilience, problem-solving, self-esteem, life & social skills**  **Kia kaha tamariki *[5-12 years]***  **Kia kaha te taiohi *[13-17 years]***  **Kia kaha nga pakeke *[18 years & over]*** |  |
| **Mahara Programme *for* Mindfulness** |  |
| **Moni Programme [Money for Kids Programme] *[8-14 years]*** |  |
| **ProMPT Programme [Pro-Motion Bowel Training Programme]** |  |
| **Relax Kids Programme *[3 years & over]*** |  |
| **S.A.P Programme [Substance Abuse Protection Programme] specifically *for* individuals with FASD or other neuro-disability *[10 years & over]*** |  |
| **SASSIE Programme [FASD School & Student Support in Education]** |  |
| **S.O.S Programme [Pūkenga Pāpori] *for* Social Skills *[4 years & over]*** |  |
| **Sunrise Programme [Whitinga Programme]**  ***for* adults with a neuro-disability** |  |
| **Workshop: Conduct Disorder** |  |
| **Workshop: FASD in Education** |  |
| **Workshop: Living with FASD** |  |
| **Workshop: Living with a Neuro-disability** |  |
| **Workshop: Youth and Justice** |  |
| **Youth Life Skills Programme [Pūkenga Ora Programme] *[13-18 years]*** |  |

***April 2018***

**If the individual or organisation meets one of the referral criteria set out in this form, please return the completed referral form to:**

**Service Referral Co-ordinator**

***BEACON* Aotearoa**

**PO Box 211**

**Napier 4140**

***OR***

**Attach the referral form to an e-mail and send to:** [**beaconaotearoa@gmail.com**](mailto:beaconaotearoa@gmail.com)

**If you are unsure as to whether or not your individual or organisation meets the referral criteria and wish to discuss this further, please e-mail [see above] or phone us:**

**Kim: 027 2414-027 *Service Referral Co-ordinator***

**Lisa: 027 841-5530**



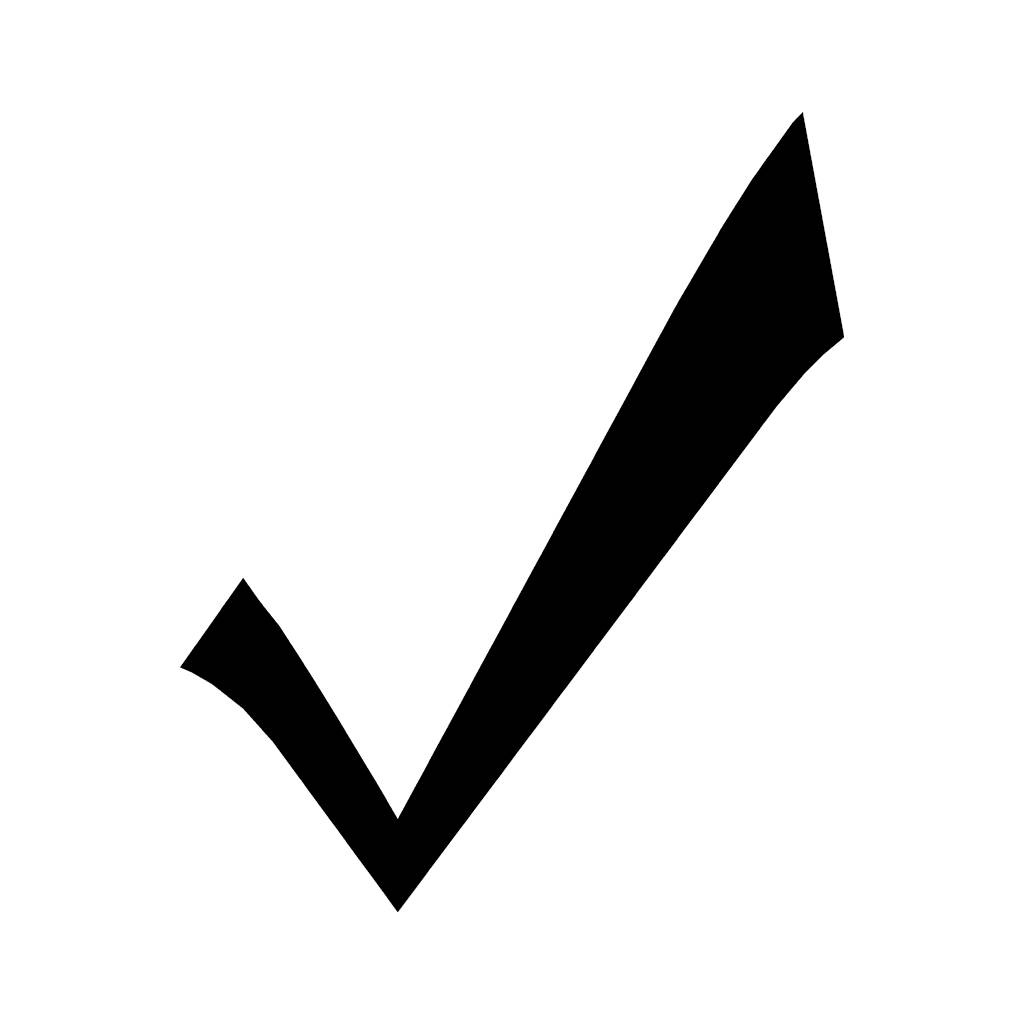
***BEACON* Aotearoa**

**PROGRAMME AND SERVICE**

**REFERRAL FORM**



**I am referring an individual/organisation to your service who meets one of the following criteria:**

**[Please tick**  **those that apply]**

|  |  |
| --- | --- |
|  | **An individual diagnosed with FASD** |
|  | **An individual diagnosed as “At Risk for Neurodevelopmental Disorder and FASD”** |
|  | **An individual diagnosed with another neuro-disability: [please list diagnoses]\*** |
|  | **1.** |
|  | **2.** |
|  | **3.** |
|  | **An individual with no formal diagnosis but with: [tick Tick Mark In WORD - Clipart library those that apply]** |
|  | * **Behavioural issues** |
|  | * **Learning issues** |
|  | * **Executive and adaptive**   **functioning issues** |
|  | * **Sensory dysregulation issues** |
|  | **A parent/caregiver of an individual who meets the referral criteria** |
|  | **An organisation who supports an individual who meets the referral criteria** |

\* Examples of other neuro-disabilities [brain-based disabilities] include, but are not limited to:

|  |  |
| --- | --- |
| * Attention Deficit Disorder [ADD] * Attention Deficit Hyperactivity Disorder [ADHD] * Autism Spectrum Disorder [ASD] | * Conduct Disorder [CD] * Oppositional Defiance   Disorder [ODD]   * Sensory Processing   Disorder [SPD]   * Aspergers Syndrome |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

###### ***BEACON* Aotearoa**

***SHINING LIGHT ON FETAL ALCOHOL SPECTRUM DISORDER [FASD]***

***AND NEURO-DISABILITY***

**E TIAHO ANA TE MARAMA i RUNGA**

**i FETAL WAIPIRO TŪĀWHIORANGI WHAKARARURARU [FASD]**

**ME NEURO-HAUĀTANGA**