Referral for Services

Catholic Social Services
people helping people āwhina tātou

Referrers Details

Referring Agency: _____

Contact Person (Full Name): _____

Role (e.g. Social Worker, GP): _____

Address: _____

Phone: _____

Email: _____

Is the referral related to family harm? **Yes / No**

If yes, are Police or Probation currently involved? **Yes / No**

Other agencies or professionals currently involved with the client (if any):

Agency Name	Name of Contact	Contact Details

Client Details

Last name: _____ **First name:** _____

Date of birth: _____ **Gender:** _____

Address: _____

Phone: _____

Email: _____

Ethnicity: _____ **Iwi Affiliation:** _____

Significant relationships (if relevant): _____

Whānau / Household Members

Please include anyone living in the household or who plays a significant role in the client's life)

Name	DOB/Age	Gender	Ethnicity	Relationship	Address / contact details if different

Phone: 027 4055 469 04-385-8642
Email: reception@cadw.nz
Address: Compassion Centre Soup Kitchen, Level 1, 132 Tory St, Wellington

Catholic Archdiocese of Wellington
Te Rohe Pīhopa Matua Katorika o te Ūpoko o te Ika

Reason for referral (please include any relevant background or recent events):
Are there any known risks or safety concerns we should be aware of?
Is there anything we should know to help keep our staff and the client safe during visits or contact?
Any other information that may help us support the client effectively:

Client's Permission

Has the client given permission for their details to be shared with Catholic Social Services so we can contact them directly to offer support? **Yes / No**

Referrer's signature:

Date:

Thank you for taking the time to complete this referral, please return to reception@cadw.nz