**AGENCY REFERRAL FOR SERVICE**

**PRE-REFERRAL CHECKLIST**

[ ]  Have you completed a record review?

*This involves going through previous assessments and documents to ensure you have an up-to-date history of the child or young person you are referring.*

[ ]  Have you actioned previous recommendations which may have an impact on current needs?

*These may be recommendations which have come from previous assessments or professionals (e.g. paediatrician report, previous cognitive assessment etc.).*

[ ]  Do you have up to date information regarding the child or young person you are referring?

*Have you had a discussion within the last 2 months with all those involved in supporting the child or young person? This might include teacher, caregiver, paediatrician etc.*

[ ]  Have you checked the information sheets regarding assessment decisions?

*If you do not have a copy, please visit our website (altogetherpsychology.co.nz) to download.*

[ ]  Have you followed the correct procedure on the Altogether Psychology referral flowchart?

*If you do not have a copy, please visit our website (altogetherpsychology.co.nz) to download.*

[ ]  Have you discussed the referral with the child/young person, whānau, and/or caregivers to ensure they understand who you are making the referral to and why?

*Please note that we will have an in-depth discussion around assessment/service type, but it is important the child/young person, whānau, and/or caregivers understand your concerns, and what support you are hoping to access.*

Signed: Date:

**REFERRAL DETAILS**

|  |  |
| --- | --- |
| **Date of referral:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of child/young person:**  |  | (First name) |  | (Last name) |
|  |
| **Child/Young person details:** | **Referrer details:** |
| D.O.B: |  | Referrer name: |  |
| Gender Identification: |  | Referrer role: |  |
| Ethnicity: |  | Referrer contact number: |  |
| Iwi/Tribe affiliation: |  | Referrer email address: |  |
| Parent/Caregiver contact number: |  | Supervisor name: |  |
| Main address: |  | Supervisor email address: |  |
| Briefly outline the reasons for this referral: |
|  |
| Briefly outline the ideal outcome for this referral: |
|  |
|  |  |

**Service requested**

Use the tick boxes below to indicate the requested service(s).

[ ]  **Assessment**

*(Please list types of assessment requested below)*

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| --- |
|  |

[ ]  **Behaviour management support**

[ ]  **Implementation support**

[ ] **Collaborative planning**

[ ]  **Targeted professional development**

[ ]  **Other**

*(Please detail below):*

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*Note: All of our assessment services will automatically include an initial consultation and a minimum of two feedback sessions charged at our standard hourly rate. If you wish to opt out of these sessions, please include an explanation below.*

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**Additional information**

***Please provide any other information you feel would be useful***

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***Please send completed referral form and consent form to*** ***referrals@altogetherpsychology.co.nz******. You can expect a response within 5 working days. If you have not received a response, please phone Johanna on 0273107364 or Ange on 0223154060.***

***Once your referral has been received, you will be contacted for an initial consult meeting.***