**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)*

|  |
| --- |
|  |

**Behaviour management support**

**Implementation support**

**Collaborative planning**

**Targeted professional development**

**Other**

*(Please detail below):*

|  |
| --- |
|  |

*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.*

|  |
| --- |
|  |

**Additional information**

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

|  |
| --- |
|  |

***Please send completed referral form and consent form to*** [***referrals@altogetherpsychology.co.nz***](mailto: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.***