



Youth Worker Referral Form

Email to: hannah@cyctrust.org.nz

CONFIDENTIAL

Young Persons Details

First Name(s):

Last Name:

Gender:

A.K.A:

D.O.B: / /

Referral Date: / /

Ethnicity:

School & year:

Siblings Name:

Gender:

D.O.B: / /

Parents/Caregivers Details

Given Name:

Last Name:

Address:

Phone:

Mobile:

Email:

Relationship to young person:

INITIATING AGENCY / WORKER

Name:

Mobile:

Email:

Agency:

Other agencies involved (e.g. CYFS, OT, WDHB, School, Police, Strengthening Families)

Background Information:

(Historical information/ issues that impact on presenting issues)

Reason for Referral:

(What are the presenting issues/ current concerns and/ or issues to be addressed?)

Which area of support could this young person benefit from? (Tick all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Improving Self Esteem | <input type="checkbox"/> Social Connection |
| <input type="checkbox"/> Flourish Evening | <input type="checkbox"/> Extra-Curricular Activities |
| <input type="checkbox"/> Chix Programme | <input type="checkbox"/> Counselling |
| <input type="checkbox"/> Rite Journey Programme | <input type="checkbox"/> Youth Service Coach |
| <input type="checkbox"/> Coping Techniques | |
| <input type="checkbox"/> Coast Mentoring | |

Intervention/ Action to date:

Other relevant information:

Consent: This young person has consented to the 24-7 Youth Worker having this information.

TEAM LEADER USE ONLY

Name of Youth Worker Allocated:
Date added to the Waitlist:
Date of first action: