



Early Start Project

PO BOX 21013, EDGEWARE, CHRISTCHURCH 8143, 136 HOLLY ROAD, ST ALBANS, CHRISTCHURCH 8014
PHONE (03) 365 9087 • FAX (03) 365 9237 www.earlystart.co.nz

Referral Process

Referral Process:

1. Please complete the 'Referral for Assessment' documentation including the signed 'Consent from Parent' on page 3:
 - a. For young mothers 24 years and under from 3 months antenatal to 9 months postnatal
 - b. For mothers over 24 years from 6 months antenatal to 9 months postnatal
2. Then either fax or post the completed forms to Early Start:
 - **Fax 03 365-9237** **PO Box 21013, Edgeware, Christchurch 8143**
3. On receipt of the referral the client family will go onto our waiting list and you will be notified of the expected waiting time.
4. During the waiting time our intake Family Support Worker will:
 - a. liaise with the referrer; *and*
 - b. make contact with the client family to do an initial home visit, and then stay in telephone contact with them until they are allocated a Family Support Worker.

Criteria for referral:

1. Family lives in the Christchurch area
2. Family is willing to participate
3. Mother is pregnant or has an infant – referrals accepted 3 or 6 months antenatal (see 1a or 1b above) to 9 months postnatal
4. Parent faces two or more of the following challenges:
 - Young mother under 18 years of age
 - Limited support networks
 - Minimal antenatal care
 - Economic disadvantage and/or lack of essential resources
 - Social skills minimal and/or inadequate
 - Little or no formal educational qualifications
 - Limited experience or skills in parenting
 - Past Child Youth and Family involvement
 - Mental Health issues / depression, anxiety etc.
 - Addictions: drug, alcohol, gambling
 - Involvement with the criminal justice system
 - Difficult family relationships – history of abuse
 - Relationship problems
 - Moved at least twice in the last 12 months
 - Additional baby needs: premature, low birth weight, special needs



Early Start Project

PO BOX 21013, EDGEWARE, CHRISTCHURCH 8143, 136 HOLLY ROAD, ST ALBANS, CHRISTCHURCH 8014
PHONE (03) 365 9087 • FAX (03) 365 9237 www.earlystart.co.nz

REFERRAL FOR ASSESSMENT

Referral Agency Details

Referral agency: _____

Name of referral person: _____

Agency Address: _____

_____ Telephone: _____

Fax: _____ Date of referral: _____

Consent from family: YES NO

Whanau / Aiga / Family Details

Mother's name: _____

Address: _____

DoB: _____ Telephone: _____ Ethnicity: _____

Father's name: _____

Address: _____

DoB: _____ Telephone: _____ Ethnicity: _____

Baby's name: _____ Date of birth: _____ Age: _____

Ethnicity: _____ Gender: M F

If mother in second or third trimester of pregnancy Expected date of birth: _____

Other Children in the Family

Name	Gender	Ethnicity	Date of Birth
_____	M F	_____	_____
_____	M F	_____	_____
_____	M F	_____	_____

Entry Criteria

Please tick the appropriate boxes



Family Challenges

I am a young mother under 18 years	
I do not have many support networks I can rely on	
I started late antenatal care or did not make use of regular antenatal care	
I have difficulties with depression, anxiety etc.	
I have difficulties with addictions – eg drug, alcohol, gambling	
My family relationships can be problematic and stressful	
I am involved with the Criminal Justice System or have had involvement with the CJS in the past	
My partner relationship is difficult at times – I do not feel supported, we argue a lot	
I have difficulties with housing, transport and or meeting the expenses of day to day living, e.g. electricity bills, rent, food, clothing.	
I have moved at least twice in the last 12 months	
I left school early	
I want to improve my social skills: e.g. feeling good about myself, getting on with others, home management, budgeting, asking for what I need, learning to take care of myself and my family	
I do not have a lot of experience or confidence in parenting and want to learn to be a good parent	
I have had involvement with the Child Youth and Family Services	
My baby has needs: pre-maturity; low birth weight; special needs	

Other:.....
.....
.....
.....

Additional Information:

Is this family engaged with or have they been referred to any other Agency (e.g. Waipuna, Safer Families, Child Wise, PAFT or New Start etc.)? **YES** **NO**

If **YES** please put name of Agency and date of referral if known: _____

Referrer:

I have explained how the Early Start Service can offer support to this mother and her family and have gained consent to forward a referral to Early Start.

Referrers Name: _____ **Signature:** _____



Early Start Project

PO BOX 21013, EDGEWARE, CHRISTCHURCH 8143, 136 HOLLY ROAD, ST ALBANS, CHRISTCHURCH 8014
PHONE (03) 365 9087 • FAX (03) 365 9237 www.earlystart.co.nz

Consent from parent to refer to Early Start for assessment

Mother / Parent:

I give consent to have a referral for assessment forwarded to Early Start.

Early Start operates a waiting list and the referring agency will be notified how long the waiting time will be. Waiting times are variable and can range from as little as 4 weeks (or sooner) or stretch to 12 weeks or more.

When a vacancy arises the referring agency and I will be notified. At that point:

- Early Start will write to me and welcome me to the Service.
- A Family Support Worker will either visit or telephone me

The Service is free and my participation is voluntary.

Parent's Name: _____

Signature: _____

Date: _____