Early Start Project
PO Box 21013, Edgeware, Christchurch 8143 56 Shirley Rd, Christchurch 8013
Phone (03) 365 9087 Fax (03) 365 9237 www.earlystart.co.nz

REFERRAL FOR ASSESSMENT

Self-Referral

Date of referral:_____

Whanau / Aiga / Family Details

Mother's name:_____ First language:_____

Address:_____

DoB:_____ Ethnicity:_____

Landline:_____ Mobile phone:_____

Father's name:_____ First language:_____

Address:_____

DoB:_____ Ethnicity:_____

Landline:_____ Mobile phone:_____

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

Ethnicity:_____ Gender: M F

If currently pregnant *- Expected date of birth:*_____

Other Children in the Family

Name	Gender	Ethnicity	Date of Birth	Address if different
_____	M F	_____	_____	_____
_____	M F	_____	_____	_____
_____	M F	_____	_____	_____

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Entry Criteria *(Please tick the appropriate boxes)*

Family Challenges

	✔
I am under 18 and have other challenges	
I started late antenatal care **or** did not make use of regular antenatal care	
I have or have had difficulties with depression, anxiety, mental health	
I have significant difficulties with drugs, alcohol, gambling	
My family relationships can be problematic and stressful	
Child Youth and Family have in the past been involved with my family or are currently involved	
My baby has needs: pre-maturity; low birth weight; special needs, health & development issues	
I have experienced abuse as a child	
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 and clothing.	
I and/or my family have been in trouble with the police	
I struggled at school and left early	
I have moved at least twice in the last 12 months	
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 do not have many support networks I can rely on	

Other:_____

_____

_____

Additional Information:

Has your family 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:_____

Please sign the consent on page 3

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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 Project.

Waiting List:

Early Start Project operates a waiting list; the waiting times are variable and can range from as little as 4 weeks (or sooner) or stretch to 16 weeks or more.

When a vacancy arises I understand that:

- Early Start Project will write to me and welcome me to the Service.
- A Family Support Worker will make contact with me by telephone or text to arrange a visit.
- The Service is free and my participation is voluntary.

Parent's Name: _____

Signature: _____ **Date:** _____

Breastfeeding Support for Mothers 24 years and Younger:

Would you like Early Start Project to send you information about the Te Māhuri Breastfeeding Group? **YES** **NO**

By answering **YES** to the above question I give consent for my name, baby's name and phone number to be passed on to the Te Māhuri Breastfeeding Group facilitators.

Do you live in Shirley, Mairehau, Dallington, Burwood, Richmond or St Albans? The Shirley Hub at 69B Briggs Road is part of Early Start. You are very welcome to 'drop in' while you are waiting to meet an Early Start Family Support Worker. Would you like Early Start to post you a brochure about this? **YES** **NO**