Young Parents' Hope Referral

Waipuna Young Parents Hope Service

Young parents have many hopes and goals for their families. We are a service that supports young parents in the process of achieving these. Some goals that have been identified as important by young parents are: a warm safe home and enough money to live on; to feel good about themselves and to make good choices; access to further education and employment opportunities; how to provide gentle guidance and clear boundaries to their children; to have fun and enjoy life.

This can be through social housing opportunities, parenting, self-development, social and activity-based groups, and in some cases may include home-based support.

To make a referral to the Young Parents' Hope Team, please fill in this referral form and email, fax or mail it to:

Fax	03 386 2158
Mail	St John of God Waipuna, P O Box 24127, Eastgate, Christchurch
Email:	referralswaipuna@sjog.org.nz
Online:	www.sjog.org.nz and look under 'other services'

Please note that it is necessary for the young person to be aware of the referral.

Client Criteria:

Parents *18-25 years*:
We offer a one on one social work wraparound service to all our clients in the HOPE Housing initiative; we also have a range of group education and support programmes within our Young Parents Development Service.

St John of God Hauora Trust

Young Parents' Hope Service
Referral Form

Referral date: ________/_______/________

Type of referral: **SELF REFERRAL** ☐
AGENCY REFERRAL ☐

→ **Is the young person referred aware of referral?** ☐ **Yes** / ☐ **No**

Client Information:

Name		Gender: ☐ Female ☐ Male
Address		
Telephone		
Email Address		
NHI:		
Date of Birth	/ /	School

Ethnicity: ☐ Maori → Please indicate iwi/tribal affiliation: ______________________________
☐ Samoan ☐ Tongan ☐ Fijian ☐ Niuean ☐ Cook Island
☐ NZ European ☐ Other (Please indicate)

Children or Estimated Date of Delivery:

Name	**Gender**	**DOB**	**Ethnicity** (if applicable provide iwi)
	M / F		
	M / F		
	M / F		
EDD (Estimated Delivery Date)			

Reasons for Referral: Have these been discussed with the client? ☐ Yes / ☐ No

Tick all that apply.

☐	Alcohol/Drug Dependence or Abuse	☐	Anger Management Issues
☐	Behavioural Issues	☐	Attachment
☐	Custody/Access/Paternity Issues	☐	Bullying
☐	Family Conflict	☐	Currently Pregnant
☐	Financial/Budgeting/Resource Issues	☐	Family Violence
☐	Grief/Loss Issues	☐	Gambling
☐	Isolation	☐	Housing/Accommodation Issues
☐	Learning Difficulties/Literacy	☐	Lack of Support
☐	Mental Health Issues	☐	Legal/Court Issues
☐	Physical/Psychological Abuse or Neglect	☐	Parenting Support/Issues
☐	Sexual Abuse	☐	Relationship Issues
☐	Social Skills/Peer Problems	☐	Self Harm
☐	Truancy Issues	☐	Suicidal Behaviour
☐	Youth Offending	☐	Self-Esteem Issues
☐	YP2B Pregnancy & Parenting Education	☐	Young Parent 14 – 19 yrs

Referring Agency:

Agency's Name	
Referrer's Name	
Role	
Telephone	
Email	
Address	
Will you be having ongoing contact with the person being referred after this referral? ☐ Yes / ☐ No If yes, what do you see your role as being and what areas will you be assisting with?	

Children or estimated Date of Delivery:

Name	DOB	Gender	Ethnicity (if applicable iwi)
		M/F	
		M/F	
		M/F	

Current Living Circumstances

Are you currently living with:
Partner ☐
Family ☐
Renting/Boarding ☐
Alone ☐
Other: ____

Do you need help/assistance with accommodation? **Yes** ☐ **No** ☐

Medical Information

	Yes	**No**
Do you have a midwife?	☐	☐
If so who? (If not we can help you find one)	______________________________	
Do you have a GP	☐	☐
If so who?	______________________________	
Have you been/are you involved with mental health services?	☐	☐
Please state any services you are Currently involved with	______________________________	

	Yes	No	
Do you have a mental health services?	☐	☐	
How often do you use:	**Do not use**	**Use once a Week**	**Use Several Times a week**
Alcohol	☐	☐	☐
Cannabis	☐	☐	☐

Other substances (Please identify) ____

	Yes	No
Do you smoke?	☐	☐
Would you like support to create a smoke free environment for your baby?	☐	☐

Family Safety and Support

	Yes	No
I am no longer with the mother/father of my child and am having difficulties with contact?	☐	☐
I want assistance with an access plan	☐	☐
I am currently going through mediation	☐	☐
I have care and safety concerns when my child is spending time with her/his mother or father?	☐	☐
Have you experienced family violence?	☐	☐
Have you been affected by violence in the past?	☐	☐
Do you have a Protection Order?	☐	☐
Have you completed an anger management course?	☐	☐
Past: Did you grow up in Child Youth and Family Services (CYFS) Care?	☐	☐
Current: Are they investigating any Concerns?	☐	☐
Current: my child is in CYF Custody?	☐	☐
Current: workers details?	☐	☐
Are you seeing other professional support in the community?	☐	☐

Past Support? (Please list) ____

Who do you identify as you main Support people? (Please list) ____

____