Referral for Assessment

Mosaic

Male Survivors of Sexual Abuse Wellington

Mosaic accepts referrals from individuals and agencies upon full completion of this form. As a confidential service, we adhere to strict Data Governance processes and will only provide information on any referral, other than receipt, with prior consent from the individual being referred.	Phone or txt: *022 419 3416* Return via Fax on: *04 389 5050* Email: *enquiries@mosaic-wgtn.org.nz* Post: P.O. Box 7682, Newtown, Wgtn

Referral Details

Referral Type: **Self** **Professional**	Via: **Post** **Tel** **Fax** **Email** **Fb**	**Referral Date** __ / __ / 201_

Referral Source (Where did the person hear about us) :

Referring agency/individual information:

Contact Details

Surname:	First Name: Preferred Name:	Date of Birth:
Suburb:	Preferred Contact Method: **Text** **Phone** **Email** **Voicemail** **Write** **Fb**	
Email:	Phone:	

Contact details and/or address:

Diversity Indicators: To ensure we are able to continue to fully meet the needs of a diverse client group, it is important we are able to collect demographic information.

Preferred Gender Identification: _____

Was this the gender you were assigned at birth? **Yes** **No** **Declined**

Ethnicity: **Maori** **Pacifica** **European/Pākehā**
Declined

Or please let us know below:

Iwi: **Hapū**:

Sexuality/sexual orientation:
Declined

Religious/Cultural Beliefs:
Declined

Do you consider yourself to have any physical or intellectual disability, if so please list below:
Declined

Relationship Status:	Number of dependants/Children:

Risk Indicator Information

Risk to self:	**High**	**Medium**	**Low**	Risk to others:	**High**	**Medium**	**Low**

Risk Details:

Please return all completed forms to **enquiries@mosaic-wgtn.org.nz** or post mail to P. O. Box 7682, Newtown – Wellington; Phone +64 22 419 3416 and we can take your referral by telephone, or Fax to 04 389 5050. Extra copies can be downloaded from www.mosaic-wgtn.org.nz

Referral for Assessment

Mosaic

Male Survivors of Sexual Abuse Wellington

Clinical Information and Common Survivor Impact Indicators
Do you have a current or historical mental health diagnosis? If so please provide information below:
Do you feel you have, or have had, any issues with drugs (illicit or not), alcohol or both? If so please provide information below:
Have you been prescribed any mental health medication or anti-depressants? Please state name and dose:

Referral Information
Please briefly state reason for referral:
When was the offence(s) committed? **< 12 Months ago (current)** **13 months + (Non-Current)**
Age at Time of Offence: **< 13** **13-19** **20-24** **25-29** **30-39** **40-49** **50-59** **60+**
Age and Gender of Perpetrator (if known): _____ (Age) Male(s) Female(s) Male and Female (couple) **Declined**
Relationship to Perpetrator: Family Member / Partner / Ex-Partner / Known Associate / Stranger **Declined**

Legal Pathway Information - Please note: Mosaic believes that making a formal complaint to the Police is entirely the choice of the individual and we do not encourage or discourage anyone from this procedure.	
Have the police been involved in any kind of investigation relating to the reason for this referral? **Yes** **No** **Declined**	Have any other services been in contact with you in relation to this referral? **Yes** **No** **Declined** If yes, has an ACC claim been filed? **Yes** **No** **Yes, but claim was declined**
Have you ever been convicted of a sexual or violent offence? **Yes** **No** If Yes please list reasons below:	

Completed by (Name and Signature)

External Agency referrer's name (if applicable)

Please return all completed forms to **enquiries@mosaic-wgtn.org.nz** or post mail to P. O. Box 7682, Newtown – Wellington; Phone +64 22 419 3416 and we can take your referral by telephone, or Fax to 04 389 5050. Extra copies can be downloaded from www.mosaic-wgtn.org.nz