Play Therapy

Ōtepoti (Dunedin) Referral Form

Date: _____ Referred by: _____

Agency/Service: _____

Phone: _____ Email: _____

Client Details

Name: _____ DOB: _____

Address: _____

Phone/Mobile: _____ Email: _____

Ethnicity: _____

Parent/Caregiver Details

Parent A

Name: _____ DOB: _____

Relationship to client: _____

Address: _____

Phone/Mobile: _____ Email: _____

Ethnicity/Iwi Affiliation: _____

Parent B

Name: _____ DOB: _____

Relationship to client: _____

Address: _____

Phone/Mobile: _____ Email: _____

Ethnicity/Iwi Affiliation: _____

Household Composition

Adult/s (Name/s): _____

Child (Name): _____ DOB: _____ M/F

Child (Name): _____ DOB: _____ M/F

Child (Name): _____ DOB: _____ M/F

Child (Name): _____ DOB: _____ M/F

Child (Name): _____ DOB: _____ M/F

Reasons for referral:

Further comments:

Other agencies involved:

Family consent to referral ☐

Both parents are aware of the referral and consent to referral ☐

Please forward either by email to PlayTherapy@FamilyCare.org.nz, or by mail to:

Kirsten Eden-Mann
Anglican Family Care
266 Hanover Street
Dunedin 9016

Please feel free to phone or email to discuss this referral with us further:
Phone: 0800 FAM CARE or (03) 477 0801 Fax: (03) 477 0888
Email: PlayTherapy@FamilyCare.org.nz