

Women's Weekend Retreats Referral

This referral must be completed by a BOP Therapy Foundation approved Counsellor, Social Worker, Mental Health Worker or 'Other' Health Professional, with permission from the Applicant.

The criteria for this retreat is that participants:

1. Must be experiencing stress-related difficulties
2. Would find it financially difficult to take a break
3. Are in a caregiving role in some capacity eg. disabled person, parent, grandparent, partner or a professional role that is responsible for others

Referrer details

Please let us know your details

Name *

First Name

Last Name

Organisation Name *

Title *

Counsellor

Psychologist

Mental Health Worker

Health Professional

Pastor

Other

E-mail *

example@example.com

Phone Number *

As a referrer, based on the criteria provided, I believe the person I am referring meets the Women's Retreat criteria. I am confident that she is not displaying any behaviour or current conditions which may place herself

or other participants at risk and would benefit from the rest, recuperation and support provided by the Bay Restore Women's Retreat (funded through Bay of Plenty Therapy Foundation).

Date *

Month Day Year

Retreat Dates

Please indicate which retreat you are referring for. We do our best to accommodate requests but referrals are subject to confirmation.

Which retreat are you referring for? *

Referee Details

Please provide the details of the person the referral is being made for

Name *

First Name Last Name

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

E-mail *

example@example.com

Phone Number *

Cultural Identity *

Collected for statistical purposes only, individuals will not be identified

Age Group *

Collected for statistical purposes only, individuals will not be identified

Who is care being provided for *

Collected for statistical purposes only, individuals will not be identified

Information about the person being referred

To be completed by or with the person being referred

Are you experiencing any of the following?

Yes No

Stress-related difficulties

Anxiety

Depression (mild to moderate)

Issues with alcohol and/or drugs

Domestic violence issues

Are you on any prescription medication? *

Yes

No

If you answer "Yes" to being on prescription medication please list below everything you are taking.

If you have any significant allergies or medical conditions we may need to be aware of, please record details below.

Please bring your own EpiPen or medication if required, which you must be able to self-administer as we do not have medical staff present.

Please indicate any special dietary requirements or restrictions arising from allergies or intolerances mentioned above.

Do you understand that you need to

Yes No Not applicable

Participate in a three-day residential retreat

Be willing to engage in developing a follow-up plan with your referrer (if necessary)

Refrain from any non-prescriptive drugs or alcohol throughout the retreat

Support Person

A family member or friend who will be able to collect you if needed

Name *

First Name

Last Name

Phone Number *

Please enter a valid phone number.

Alternative Phone Number

Please enter a valid phone number.

As a participant I understand the criteria for being accepted to attend a retreat and confirm that I would like to engage in a Retreat for Women that offers education and rest.

I also understand and agree that:

- I am happy to be contacted by Bay Restore Women's Retreat Facilitator for assessment purposes prior to the retreat (if necessary)
- it is not a counselling retreat and that facilitators are unable to provide one-on-one counselling support.
- if I begin to experience levels of distress and am finding it difficult to cope, I agree that I will go home (the facilitators will check with you to see if you feel safe to drive home or whether you would like your support person to collect you)

Date *

Tick box (left) to indicate you understand and agree to the criteria listed above

Month Day Year