



Referral Form

Mental Health & Addiction Services

Private Bag 12024
Tauranga
Ph 07 577 6452
Fax 07 571 8647

Whakatane
ph 07 306 0154
Fax 07 308 9675

Immediate significant risk of safety to self or others due to mental illness has to be referred directly to the psychiatric crisis service 0800-800-508. If necessary the police

PLEASE TICK APPROPRIATE BOX:

<input type="checkbox"/> CRISIS TEAM	<input type="checkbox"/> CHILD & ADOLESCENT	<input type="checkbox"/> EARLY INTERVENTION	<input type="checkbox"/> ALCOHOL & DRUG
<input type="checkbox"/> KAUPAPA MAORI	<input type="checkbox"/> COMMUNITY MENTAL HEALTH	<input type="checkbox"/> MHS FOR OLDER PEOPLE	<input type="checkbox"/> MATERNAL MENTAL HEALTH
<input type="checkbox"/> DUAL DISABILITY SERVICE			

INTERNAL REFERRALS ONLY:			
<input type="checkbox"/> LIAISON PSYCHIATRY	<input type="checkbox"/> INTENSIVE CASE MANAGEMENT	<input type="checkbox"/> TE WHARE MAIANGIANGI	<input type="checkbox"/> MHSOP DAY HOSPITAL

CLIENT INFORMATION

<input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MISS <input type="checkbox"/> MS	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SURNAME / FAMILY NAME	GIVEN NAMES:	
			PREVIOUS NAMES/ ALSO KNOWN AS:	
RESIDENTIAL ADDRESS:		POSTAL ADDRESS (IF DIFFERENT FROM RESIDENTIAL):		
HOME PH:	WORK PH:	MOBILE:	OTHER:	
DATE OF BIRTH:	COUNTRY OF BIRTH:	NHI NUMBER (IF KNOWN)	OCCUPATION/SCHOOL	
PREFERRED LANGUAGE: INTERPRETER REQUIRED: <input type="checkbox"/> YES <input type="checkbox"/> NO		NEW ZEALAND RESIDENT: <input type="checkbox"/> YES <input type="checkbox"/> NO	YEARS OF RESIDENCE IN NZ?	
WHICH ETHNIC GROUP DO THEY BELONG TO? MARK THE SPACE OR SPACES THAT APPLY TO THEM.				
<input type="checkbox"/> NEW ZEALAND EUROPEAN	<input type="checkbox"/> CHINESE	OTHER (SUCH AS DUTCH, JAPANESE, TOKELAUAN), PLEASE STATE: _____		
<input type="checkbox"/> MAORI	<input type="checkbox"/> TONGAN			
<input type="checkbox"/> SAMOAN	<input type="checkbox"/> NIUEAN			
<input type="checkbox"/> COOK ISLAND MAORI	<input type="checkbox"/> INDIAN			

LEGAL CONSIDERATIONS

<input type="checkbox"/> MENTAL HEALTH ACT	<input type="checkbox"/> CRIMINAL JUSTICE ACT	<input type="checkbox"/> CARE & PROTECTION	<input type="checkbox"/> ENDURING POWER OF ATTORNEY
<input type="checkbox"/> OTHER SPECIFY:			

PREFERRED CONTACT PERSON: RELATIONSHIP: PH NUMBER:	OTHERS LIVING AT HOME:
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CARER/GUARDIAN FOR CLIENTS IF APPLICABLE

NAME:	ADDRESS (IF DIFFERENT FROM ABOVE)
CONTACT No:	
RELATIONSHIP TO CLIENT:	
<input type="checkbox"/> PLEASE TICK IF CARER/ GUARDIAN OR SUPPORT PERSON INTENDS ON ATTENDING THE ASSESSMENT	

DOES CLIENT AGREE WITH NECESSITY FOR REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO DETAILS:	IS CLIENT INVOLVED WITH OTHER AGENCIES? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME & DETAILS:
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TRACKING FOR MHS USE ONLY	<input type="checkbox"/> RECEIVED AND PROCESSED	<input type="checkbox"/> TICK IF ADDITIONAL INFORMATION IS ATTACHED
NAME: _____ SIGN: _____	OUTCOME:	
DATE: _____		

Surname _____ MHA Status: _____
First Names _____ NHI # _____
D.O.B. ___/___/___ *Attach patient label if available*



REASON FOR REFERRAL – BACKGROUND, CURRENT SYMPTOMS, DURATION & EFFECTS ON CURRENT FUNCTIONING ETC

Empty box for Reason for Referral details.

PAST PSYCHIATRIC HISTORY (IF ANY)

Empty box for Past Psychiatric History details.

OTHER HEALTH / DISABILITY INFORMATION – INCLUDING CURRENT TREATMENT, MEDICATIONS ANY RELEVANT RECENT TEST OR INVESTIGATIONS

Empty box for Other Health / Disability Information details.

IDENTIFIED RISK ISSUES

Empty box for Identified Risk Issues details.

GENERAL PRACTITIONER NAME & ADDRESS:

REFERRER NAME & ADDRESS (IF DIFFERENT FROM GP)

TELEPHONE:

FAX:

TELEPHONE:

FAX:

DATE: _____

SIGNATURE: _____