**Youth AOD Service**
**Bay of Plenty District Health Board**
*Telephone (Direct Line): 07 557 5052 or*
*0800 BAY SORT (0800 229 7678)*
*Fax: 07 578 7961*

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

# SORTED YOUTH AOD SERVICE REFERRAL

*Please type or print clearly*

Name of Child/Young Person: _____ NHI: _____

Age: _____ Gender: _____ DOB: _____

Ethnicity: _____ Iwi: _____

Address: _____

Phone: Home: _____ Cell: _____ Work: _____

School: _____ Year: _____

Parents/Caregivers: _____

Relationship to young person: _____

Address *(if different from above)*: _____

Phone: Home: _____ Cell: _____ Work: _____

Does the client consent to this referral? ☐ Yes: ☐ No:
*(if under 16 then parental consent is preferable)*

Situation & Background *(include current substance use, reason for referral).*

Referrer name and contact details:

_____

FM.R4.36 8425 03/17

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*Please tick if any of these concerns present?*

- ☐ Phobias or worries
- ☐ Low mood
- ☐ Attention and concentration difficulties
- ☐ Eating difficulties
- ☐ Violence / aggression
- ☐ Suicidal thoughts
- ☐ Self-harming behaviours
- ☐ Hallucinations, confused thinking / behaviour
- ☐ Problematic gaming
- ☐ Behaviour leading to mental health concerns *(e.g. elation, withdrawal, obsessions, compulsions)*

Medications: _____

Other services involved: _____

Please explain further regarding ALL items ticked above:

Other Health/Disability/School Information:

Any risks to staff regarding home visits (e.g. dogs, gang association)? ☐ Yes ☐ No Explain:

*Please attach any helpful additional information to this referral*

*Please send referral to: Sorted@bopdhb.govt.nz*

*Sorted- Youth AOD Service, Private Bag 12024,Tauranga Hospital, Tauranga*

EMAIL

PRINT