Adult Mental Health & Addiction Services
Referral Form to MidCentalDHB

(To discuss referral, please also phone the destination Community Mental Health & Addiction Team)

Date of referral: _____ **Fax to: 06 350 8163**

Client name

Name:_____ _____ NHI: _____

Address: _____

Date of Birth: _____ Male / Female

GP or Consultant: _____ Area: _____

Service User Phone No. _____

email if available: _____ preferred contact time _____

Ethnic Identity	Iwi	Gender
Alias	Hapu	Village (Pacifica)
G.P.	G.P. Phone	Hahi/Religion

Name of referrer Address Phone No.	TO: Name team
Principal care-giver/Family/ Whānau Relationship	Other contact
Address Phone Number	Address Phone Number

Has the service user consented to referral? ❑**Yes** ❑**No**

Reason for Referral/Transfer (Brief Summary)

REFERRAL FORM

*NHI*_____

Current Treatment/Management Plan (or attach a copy of existing plan)

*NHI*_____

Please fill out the following fields (or attach documents/assessments which cover the content):

Risk factors ❑ Suicide intent ❑ Threats to others ❑ Aggression violence ❑ Forensic history ❑ Other	
Duration and history of situation	
Maori/Whanau/or Family -related issues	
Medical conditions and history	
Family & Personal psychiatric history	
Any recent medical examination and outcome	
Alcohol and drug use	
Any other services involved (e.g. MASH, ARLA, ACC, etc.)	
Legal status with review and expiry dates	
Other relevant information	