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|  | **Bay of Plenty Regional Kaupapa Maori NASC Mental Health & Addictions** **Referral Form****Address: 3 Lochhead Road, RD6 Te Puna, Tauranga 3176** **Phone: (07) 552 4573****Fax: (07) 552 4572** |
| **CLIENT DETAILS (referrer to complete)** |
| Title: |  ❑Mr ❑Mrs ❑ Miss ❑ Ms NHI Number: |
| Surname: |  |
| First Name(s) |  |
| Preferred Name: |  Date of Birth: |
| Home Address: |  |
|  |
| Home Phone: |  Cell Phone: |
| Living arrangements: | ❑ Client lives alone❑  |
| Mental Health Act Status: |  |
| **GENERAL MEDICAL DETAILS** |
| Name of GP: GP Phone Number:  |
| Name of any other medical specialist/services involved e.g. ACC: |
| **ETHNICITY** |
| ❑ NZ European ❑ NZ Maori ❑ Pacific ❑ Other (please state) |
| First language: Is an interpreter needed? Yes ❑ No ❑ |
| **NEXT OF KIN / CARER DETAILS** |
| Title: | ❑ Mr ❑ Mrs ❑ Miss ❑ Ms  |
| Full Name: |  |
| Relationship to Client: |  |
| Home Address: |  |
| Home Phone: |  | Work Phone: |  | Cell Phone: |  |
| **IMPORTANT!** |
| 1. Has the person you are referring given consent to release their information Yes ❑ No ❑
2. Are they requesting this service? Yes ❑ No ❑
3. If no, give reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| **REFERRAL DETAILS** |
| Name of Referrer: |  |
| Client’s Key Worker: |   |
| Name of Clinical Team or AOD Service |  |
| Contact Phone Number |  |
| Date of Referral: | Signature: |
| **REASON FOR REFERRAL** |
| What does this client hope to gain from this referral? |
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| What does the clinical team hope to gain from this referral? |
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| **CURRENT SUPPORT SERVICES** |
| List any services already working with the client/family: |
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| **RECOVERY GOALS (tick all boxes that apply)** |
| List any services already working with the client/family: |
| ❑ Medication Adherence | ❑ Community Participation | ❑ A Place to Live |
| ❑ Risk Reduction | ❑ Family Education / Support | ❑ Planned Respite |
| ❑ Symptom Stabilisation | ❑ Career Support | ❑ AoD Stabilisation |
| ❑ Return to Work / Education | ❑ Develop / Improve Independent Living Skills | ❑ Other |
| **CHECKLIST (please tick)** |
| Completed Comprehensive Assessment attached?  | ❑ Yes | ❑ No |  |
| Risk Assessment attached? | ❑ Yes | ❑ No |  |
| Cultural Assessment attached? | ❑ Yes | ❑ No | ❑ NA |
| Recovery / Relapse Plan attached? | ❑ Yes | ❑ No |  |
| Drug and Alcohol Assessment attached? | ❑ Yes | ❑ No | ❑ NA |
| Mental Health Act conditions attached? | ❑ Yes | ❑ No | ❑ NA |
| **Please note that referrals that do not contain essential information will be returned** |