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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: | | | | | | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
| **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** | | | | | | |