AOD:REF
Nov 2012

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CEP / AOD Referral Form

Client details: **IMPORTANT – Please complete all areas of this page**

Date: NHI:

Surname: First name:

Phone: Mobile:

Address:

DOB: / / Gender: ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ Maori ☐ Pakeha ☐ Pacific Islander ☐ Other please name

Iwi: Hapu:

GP/Doctor:

Emergency Contact: Phone / Mobile:

IMPORTANT:

It is very important that this referral is discussed with the client. Has the client agreed to your referral to Te Tohu o te Ora o Ngati Awa Alcohol & Drug Service? ☐ Yes ☐ No, if no you will need to consult further with the client. Where the client is **under 16 years of age**, this referral must be discussed with the caregiver / parent. Has this referral been discussed with the caregiver / parent? ☐ Yes ☐ No, if no you will need to consult further with the caregiver / parent.

Reason for referral:

☐ Drug / Substance abuse – Please State:

☐ Alcohol Abuse ☐ Mental health problem

Is the client working with any other services within Te Tohu o te Ora o Ngati Awa? ☐ Yes ☐ No

☐ Alcohol & Drugs ☐ Asthma ☐ Aukati Kai Paipa ☐ Bay facilitation SWAP ☐ CAYAD

☐ Community nurse ☐ Diabetes ☐ Family Start ☐ Iwi Social Services ☐ SWIS ☐ Tamariki Ora

Are there other agencies involved with this client? ☐ Yes – please list below ☐ No

Organisation Name	Contact Person	Contact Number

IMPORTANT: Please complete		Comments
01	**Legal Status** ☐ None ☐ Community Probation Service ☐ Court pending	Date of impending court case: / /
02	**History of mental health** ☐ Currently receiving support ☐ Conflict with non whanau members ☐ Unsupported by whanau/parents ☐ Historic issues you would like to address	
03	**Relationship issues** ☐ Family violence ☐ Lack of support ☐ Conflict	
04	**Lack of Essential Resources** ☐ Housing situation unsuitable ☐ No transport	

Referrer details:

Name: Agency / Title:

Phone: Mobile:

email: Signature:

Emailed referral can be attached by us as confirmation

OFFICE USE ONLY

Service co-ordination:

Date referral received: / / Date referral entered: / /

AoD Counsellor:

Date whanau contacted: / /

Client eligible for Service: ☐ Yes ☐ No – client referred to _____

Referrer notified of outcome: ☐ Yes - provide evidence letter or email to referrer

☐ No - please state reason: _____