



**Rangataua Mauriora**  
**Tu Te Wehi - Primary Mental Health Service**  
227 Bedford Street, Cannons Creek, Porirua  
Postal Address: PO Box 50 079, Porirua  
Phone: 237-6057 Fax: 237-6058

**REFERRAL FORM**

Referrers Name: \_\_\_\_\_ Date: \_\_\_\_\_

Surname: \_\_\_\_\_ NHI number: \_\_\_\_\_

Given names: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Other names: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation/School: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: *Home:* \_\_\_\_\_ *Mobile:* \_\_\_\_\_ *Bus:* \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Iwi: \_\_\_\_\_

General Practitioner (if different from referrer):

Next of kin/guardian:

\_\_\_\_\_

Name: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Telephone: \_\_\_\_\_

Reason for Referral: (please be as detailed as possible)

Symptoms/Behaviour of concern: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Desired Outcome: \_\_\_\_\_

\_\_\_\_\_

Brief problem history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Stressors:** \_\_\_\_\_

\_\_\_\_\_

**History of previous contact with mental health services:** \_\_\_\_\_

\_\_\_\_\_

**Current Medication and any other health/disability information:** \_\_\_\_\_

\_\_\_\_\_

**Current social/living situation – Other agencies involved:** \_\_\_\_\_

\_\_\_\_\_

**Significant others / support people:**

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Possible Disorder:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Anxiety/Phobia  | <input type="checkbox"/> Depression    | <input type="checkbox"/> PTSD            | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> Gambling issues |  |

**Other (please state):** \_\_\_\_\_

**Client consent to referral:**       **Yes**                       **No**

**Client signature:** \_\_\_\_\_