

## **REFERRAL FORM**

## PLEASE INDICATE THE MAIN ISSUE OF CONCERN

MENTAL HEAL	TH 🔟	ALCOHOL & DI	RUG 📙	вотн ⊔				
GP:		R	eferral Date:					
Referrer Name:		A	gency /Practice:					
Email:		A	ddress:					
Telephone:		_ Relationship To	Young Person:					
Young Person's Inf	<u>ormation</u>							
Name:		Dat	te of Birth:	Age:				
Gender: M / F / Diverse		NH	I:					
Ethnicity:		Iwi	:					
Address:								
Young Person's Contact Num	ber/s:							
Email:								
For young poople under t	ho ago of 16	nloaco includo r	aront/carogivor'	s contact dotails:				
For young people under the age of 16, please inc  Name: E			mail:					
Address:								
Contact Number/s:								
Referral Details								
Reason for Referral:								
Reason for Referrant								
*Safety Issues/Level of r	isk re: harm t	to self or others:						
Other agencies involved:								

Background information						
(E.g. Family situation, accommodation, education, e	employme	ent, re	elevant	history)	)	
Please attach any other relevant information/	reports i	f ava	ilable			
Does the young person support the referral? Do the parents/caregivers support the referral? Have they completed a consent form?	Yes Yes Yes		No No No	_ _		
Signed:	D	ate: _				

Please scan and email this referral to: <a href="mailto:sthcanty@adlnz.org.nz">sthcanty@adlnz.org.nz</a> or fax to (03) 684 5984 or post to 196 Evans Street, Waimataitai, Timaru 7910