



REFERRAL FORM

Young Person's Information

Name: _____ Date of Birth: _____ Age: ____ Gender: M / F

NHI Number: _____ Ethnicity _____ Iwi: _____

Address: _____

Phone(s): _____ (Home) _____ (Mobile)

Name(s) of parents/caregivers and contact details if different from young person's:

Other agencies currently or previously involved:

Referrer Information

Referrer: _____

Agency/Relationship to young person: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

Best Times to contact you: _____

Reason for Referral

(Please outline alcohol, drug and /or mental health concerns)

Alcohol and/or Other Drug use

CRAFFT	Use the CRAFFT to help decide whether a referral is appropriate. Two "yes" answers indicate a need for further assessment.	YES
Car	Has the young person ever ridden in a Car driven by someone (including themselves) who was "high" or had been using alcohol or drugs?	
Relax	Does the young person ever use alcohol or drugs to Relax , feel better about themselves, or fit in?	
Alone	Does the young person ever use alcohol or drugs while they are by themselves, Alone ?	
Forget	Does the young person ever Forget things they did while using alcohol or drugs?	
Family or Friends	Does the young person's Family or Friends ever tell them that they should cut down on their drinking or drug use?	
Trouble	Has the young person ever gotten into Trouble while they were using alcohol or drugs?	

Background information:

(E.g. Family situation, accommodation, education, employment, relevant history)

- Does the young person know about the referral? Yes No
- Do the parents/caregivers know about the referral? Yes No
- Have they completed a consent form? Yes No

Signed _____ Date: _____
Referrer

Please return this form by post to the Area Manager:

Clive McArthur
 Adventure Development
 P O Box 1255
 Invercargill

Phone: 03 218 8833
 Fax: 03 218 8834

For ADL Use:	Date Received: _____	Staff Member Receiving: _____
Next Action: _____	Date of First Appointment: _____	