

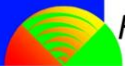
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REFERRAL to CHOICE's to WELLBEING PROGRAMME					
REFERRAL to YOUTH (General Health) CLINIC:					
REFERRAL to YOUNG DADS Programme					
CLIENT DETAILS:			MAIN CONTACT:		
			Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caregiver <input type="checkbox"/> Other <input type="checkbox"/>		
Name:			Name:		
NHI:	DOB:	Age:	Relationship to Client:		
Address:			Phone: HM:		
			MB: :		
			WK:		
Email:			ALTERNATIVE CONTACT:		
			Parent Guardian Caregiver Other		
GP:			Name:		
Gender:	Ethnicity:		Relationship to Client:		
			Phone: HM:		
Phone HM:	Mobile:		MB:		
School:	Year:		WK:		
Has the Young Person agreed to the referral?			Yes No		
<i>Important Note: Referrals into the Youth Health Hub complete a triage process where referral information is shared with Marinoto, the Adult Mental Health Primary Care Liaison Nurse, CADS or Odyssey House to determine the most appropriate pathway. If accepted for the "Choices to Wellbeing" Primary Mental Health Programme contracted providers will also receive the referral form. Please ensure this is explained to the young person prior to consenting to the referral.</i>					
Are family members aware of this referral?			Yes No		
Is it okay to leave messages when client is not available?			Home:	Yes	No
			Mob:	Yes	No
Is it okay to send correspondence to the client?			Yes No		
REFERRER DETAILS:					
Name:			Organisation:		
Address			Phone:		
			Fax:		
			Mobile:		
Relationship to client:			Email:		
Reason for referral (tick appropriate box):					
Anxiety	General Youth Health	Medication Oversight			
Grief / loss	Primary Care Follow Up	Sexual Health			
Mental Health	Chronic Health Care	Transgender Health			
Personal / relationships	Alcohol/Drugs				
Low Mood/ Depression	Family Stressors	Other (please specify)			



SUGGESTED INTERVENTION:

Family work

One to one

Group

PRESENTING ISSUES:

Other relevant information:

Family:

Medical/Health:

Current Medication:

Education:

Referrers Expectations:

Other Agencies/workers involved in Young Persons care:

Referrer:

Signed name and designation:

Date:

Please attach other relevant information: previous assessments/treatment summaries, social work reports/relevant correspondence