Referral Form

Whakatupu Ora ☆ Infant Mental Health Service

COUNTIES MANUKAU DISTRICT HEALTH BOARD
A Community Partnership

Address: 70 Kerrs Road, Wiri, Manukau 2104; PO Box 97-289, Manukau; Tel: (09) 259-5099 Fax: (09) 263-8502

Baby / Toddler

Name _____ Gender M F

D.O.B. (or due date) ____/____/_____ NHI _____

Ethnicity _____ Eligible for free public health care yes no

Primary caregiver

Relationship _____ Name _____

Age _____ Ethnicity _____ Interpreter required yes no

Contact numbers _____

Address _____

_____

Caregiver has consented to this referral yes no and to our contacting the agencies below yes no

Other Caregiver(s) (incl. address & tel.)

_____

_____

_____

Other Family members (name, relationship, age)

_____

_____

_____

Professionals involved (midwife, preschool, Early Intervention, Paediatrician, NGOs, CYFS, etc.)

GP _____

_____ Copy sent to GP yes no

_____

_____

_____

Safety concerns (abuse, domestic violence, neglect, etc.)

_____

_____

For acute safety concerns, please notify CYFS/police prior to referring to our service.

Notified CYFS yes no police yes no Details: _____

Risk rating:
high
medium
low

Main reason for referral

_____

Other Concerns about the Infant

(e.g. crying, irritability, feeding or sleeping problems, sadness, withdrawal, hyperactivity, tantrums, aggression, fears, nightmares, clinginess, relationship problems (with family or peers), developmental delay, traumas, separations, etc.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Diagnoses (including physical & developmental) & **Medications**

_____
_____
_____
_____ Reports / summaries attached yes no

Concerns about the Caregivers

(e.g. difficult relationship with baby / toddler, history of relationship trauma, past or present mental illness, substance abuse, lack of support, etc)

or **Family** (including siblings)

_____
_____
_____
_____
_____
_____
_____
_____

Family members under Mental Health services: _____

Referrer

Name _____ Profession _____

Phone(s) _____ Agency / Service _____

Address _____

Signature _____ Date ___/___/_____