ADHB Adult Mental Health Service
Regional Huntington's Service
Level 4, Support Building
Auckland City Hospital
Ph: 09 3074949 ext 25013
Fax: 09 3078945

Regional Huntington's Disease Service Referral Form

REFERRAL DATED:

CLIENT INFORMATION:

Name:	
Date of Birth:	NHI:
Address:	
Phone number:	

Fluent English speaker?	
If no, what is first language?	

REFERRER DETAILS:
Name:
Title:
Organisation:
Address: Phone: Email:

If required, any appropriate individual to provide corroborating information?
Name:
Relationship to client:
Contact Phone:
Has client provided consent for information to be obtained from this family/support person?

GENERAL INFORMATION TO BE INCLUDED IN REFERRAL:

Outline HD related motor, cognitive and/or neurobehavioural symptoms

Relevant medical, psychiatric and medication history:
Alcohol & Drugs History & Current Use:

Please enclose all relevant additional supportive documentation