tūhoe hauora
tihei mauri ora!

REFERRAL

(External/Self-Referral)

NHI NUMBER	

REFERRAL SOURCE					
SELF / WHANAU	☐	Has the client given consent to be referred to Tuhoe Hauora if not a self-referral?			☐ Yes ☐ No
EXTERNAL	☐ MVCOT	☐ Corrections	☐ DHB		☐ MOH
	☐ Community	☐ Organisation ____________________			
REFERRED TO					

CLIENT INFORMATION					
Full Name					
Address					
Phone Number					
Gender	M / F	Date of Birth		Age	
Please state if you are a NZ citizen, NZ resident with Visa (or *other* status) so that we may assess your eligibility for using publicly funded health services					

WHANAUNGA DETAILS			
Maunga		Awa	
Waka		Marae	
Hapu		Iwi	
Tipuna		Kaumatua	

NEXT OF KIN			
Name		Relationship	
Address			
Phone Number			

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Do you have any children/ young person currently living with you? (include all children, whangai, extended whanau and others)				
	Gender	M / F	D.O.B	
	Gender	M / F	D.O.B	
	Gender	M /F	D.O.B	
	Gender	M / F	D.O.B	

Would you like support for your children? (Please tick YES/NO box below)

YES ☐ NO ☐

REFERRED BY			
Name			
Contact Number		Mobile	
Address			
Email		Date	

PROBLEMS IDENTIFIED

ESSENTIAL REFERRAL CRITERIA				
☐ Experiences Mental Illness	☐ Expressing Suicidal Thoughts	☐ Respite	☐ Substance Use – Alcohol/Drug ☐ Substance Use – Other	
☐ Disabilities	☐ Kaumatua (over 50 yrs)	☐ SWiS	☐ Whanau Support	
☐ Early Intervention	☐ Social Work	☐ Mentoring	☐ Hui-a-whanau	☐ Whanau Ora
Issues relating to Alcohol or Drug Use	☐ Emotional Violence	☐ Physical Violence	☐ Sexual Violence	☐ Neglect

NON ESSENTIAL REFERRAL CRITERIA			
☐ Legal Issues Pending	☐ Behavioural	☐ Marital Strife (Communication)	☐ Relationship Difficulties
☐ Neglect	☐ Financial/Budgeting	☐ Housing	☐ Support
☐ Other ________________________________		☐ Known Medical Condition/s	

SUMMARY OF NEEDS (please provide brief outline of issues and attach any information that can support this referral)

CLINICAL INFORMATION (provide any applicable details)			
Current Mental Health Status (MH Act)		Diagnosis	
Doctor (GP)		Psychiatric Nurse	
Psychiatrist		Psychologist	
Social Worker		Other Agencies Involved	

	☐ Yes ☐ No (complete health assessment)
	☐ Yes ☐ No (complete health assessment)

INTERNAL OFFICE USE ONLY			
Referral Taken By		Date Received	
Known to Services	☐ Yes ☐ No	Caregiver's Name	
Further Action Required			