FM.R4.36 8425 03/17

Youth AOD Service
Bay of Plenty District Health Board
Telephone (Direct Line): 07 557 5052 or
0800 BAY SORT (0800 229 7678)
Fax: 07 578 7961

SORTED YOUTH AOD SERVICE REFERRAL

Please type or print clearly

Name of Child/Young Person: ______________________ NHI: __________

Age: __________ Gender: __________ DOB: __________

Ethnicity: ______________ Iwi: ______________

Address: ______________________________

Phone: Home: __________ Cell: __________ Work: __________

School: ______________________ Year: __________

Parents/Caregivers: ______________________________

Relationship to young person: ______________________________

Address *(if different from above)*: ______________________________

Phone: Home: __________ Cell: __________ Work: __________

Does the client consent to this referral? ☐ Yes: ☐ No:
(if under 16 then parental consent is preferable)

Situation & Background *(include current substance use, reason for referral).*

Referrer name and contact details:

____

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Please tick if any of these concerns present?

- ☐ Phobias or worries
- ☐ Low mood
- ☐ Attention and concentration difficulties
- ☐ Eating difficulties
- ☐ Violence / aggression
- ☐ Suicidal thoughts
- ☐ Self-harming behaviours
- ☐ Hallucinations, confused thinking / behaviour
- ☐ Problematic gaming
- ☐ Behaviour leading to mental health concerns *(e.g. elation, withdrawal, obsessions, compulsions)*

Medications: ______________________________

Other services involved: ______________________________

Please explain further regarding ALL items ticked above:

Other Health/Disability/School Information:

Any risks to staff regarding home visits (e.g. dogs, gang association)? ☐ Yes ☐ No Explain:

Please attach any helpful additional information to this referral

Please send referral to: Sorted@bopdhb.govt.nz

Sorted- Youth AOD Service, Private Bag 12024, Tauranga Hospital, Tauranga