PART A: CLIENT INFORMATION

CLIENT PERSONAL DETAILS	
Date	NHI Number (If known):
Full Name Preferred Name	Gender: Male Female
Date of Birth Place of Birth	NZ Citizen: YES NO Residential Status:
Address	
Contact Numbers	Home: Mobile: Can we leave text and/or voice messages: YES NO
Ethnicity	Iwi: Marae:
Doctor's name and contact details	
Alternative Contact Name and Number	Relationship to you:
TYPE OF SUPPORT AND SERVICES REQUIRED	
How have you been referred to our service	Self ☐ Family ☐ Justice ☐ GP ☐ Mental Health ☐ Other ☐ If 'Other' please state:
What is the reason for this referral eg: Court, WINZ, Dr, Self	
Are you pregnant	YES NO Not Applicable
Have you previously been a client of our service	YES NO If YES: Who did you see and when?
Which substance(s) are you currently using that you would like help with	
Do you have a current or past mental health issue	
Is gambling a problem for you	
Have you received a head injury in the past	YES NO If YES how does this affect you?
Which clinic would you prefer to attend	☐ Huntly ☐ Ngaruawahia ☐ Raglan ☐ Te Kauwhata

LEGAL INFORMATION	
Do you have any current charges pending:	YES NO Not Applicable If YES what are they?
Next court date:	

PART B: REFERRER INFORMATION

REFERRER'S/AGENCY DETAILS	
Name	
Agency	
Address	
Phone Number/s	
Email	

For environmental purposes, we prefer to send correspondence electronically, if you do not wish this please state so and ensure correct address details are supplied

	YES	NO
Is client aware of this referral?	☐	☐
Are you maintaining contact with the client?	☐	☐
Do you wish to be informed of initial appointment and attendance? *	☐	☐

**** Information Disclosure needs to be signed by client for release of information***
****A request for letters/certificates will incur a $25 charge and will be processed within 10working days of request***

INFORMATION DISCLOSURE

Consent to Share information

Confidentiality will be maintained at all time by the Health & Wellness Service except on disclosure of information regarding safety to self or others, where appropriate steps will be taken by the clinician to keep you and the community safe.

Information will be shared if you have a key worker who is a Health Professional. If we need to communicate with other persons and agencies, we need to obtain you permission. Information that will be shared includes attendance at sessions, overall progress towards goals, and/or further needs identified.

Please list those persons (including whanau/friends) and agencies that we have permission to communicate with:

Name	Agency/Address	Contact details

To the best of my knowledge the information supplied in this referral is true and correct

Client Signature_____ Date _____
(If you are 16years of age or under your parent/caregiver's signature is required)

If you have filled this form out on behalf of someone else please provide your full name and signature below:

Name _____ **Date** _____

Signature _____