Iwi Support Service
Referral Form

14 Rehua Place, Favona
PO Box 23300, Hunters Corner, Papatoetoe
Phone: 0800 024 321
Email: firstname@wharetiakihauora.org.nz

PLEASE READ THIS REFERRAL INFORMATION

This referral package has been developed for referring agencies, their consumers and carers to provide information for our Iwi Support Service.

All referrals must include full documentation – e.g.

- Adult Risk Assessment and Management Plan
- Relapse Prevention Partnership Plan
- Co-ordinated Care Plan
- Current Medication Prescribing Chart
- Full completion of both Part 1 of the referral to be completed by the Client and Part 2 of the referral to be completed by the Referring Agency *(If necessary, the client may require assistance to complete the self-referral section)*

Multi-disciplinary assessments/reports will assist with the commencement of an Individual Support Plan and effect a smooth transition to the Iwi Support Service.

The General Manager and Services Coordinator of Whare Tiaki Hauora will discuss the referral, and a decision will be communicated in writing to the referring agency and the client within 48 hours of receiving the completed referral package. An Iwi Support Worker will be responsible for meeting the client and orientating them to the Iwi Support Service. They will also co-ordinate assessments and work with the client to develop an individual support plan.

Whare Tiaki Hauora encourage the support and involvement of the allocated Key Worker, whanau and carers in the referral assessment, ongoing care and support of the client whilst they are working alongside our Iwi Support workers.

Please feel free to contact either the Office Administrator or the Services Coordinator of Whare Tiaki Hauora with any enquiries about the referral form and/or process.

We hope to work with you to provide quality service to all individuals referred to our Iwi Support Service.

Part 1
Self-Referral

To be completed by Client
(Please print clearly)

Full Name			
Address			
Suburb		City	
Phone		Mobile	
Email			
D.O.B		Gender	
Ethnicity		Iwi / Hapu	
Next of Kin		Phone	
Address			
Relationship			

Clinical Information

Clinical Team			
Keyworker Name		Phone	

Physical Health Information

Your Doctor's / Tohunga Name		
Healthcare Provider		
Address		
Phone		
Do you have any allergies / conditions?	☐ Yes	☐ No
If yes, please list		
Do you have any health conditions that need special care?		
If yes, please list		
Are you taking any medication?		
If yes, please list		
Have you ever smoked cigarettes?	☐ Yes	☐ No
Do you currently smoke cigarettes?	☐ Yes	☐ No
If yes, How many do you smoke daily?		
Would you like to give up smoking?		
Have you tried Nicotine Replacement Treatment?	☐ Yes	☐ No
If yes, please list		

Personal Income Information				
Are you currently employed?	☐ Yes		☐ No	
If yes, how often do you work?		**Part time *(>30 Hours per week)***		**Full Time *(<40 hours per week)***
Are you currently studying?	☐ Yes		☐ No	
If yes, Where do you study?				
Are you currently receiving a benefit?	☐ Yes		☐ No	
If yes, which benefit are you receiving?				
Which ***Work and Income*** office are you currently with?				
Personal Interests				
What kind of Hobbies / Interests do you have?				
Please tell us if you currently attend any programs, groups or activities and where?	.			

Primary reasons for requesting an Iwi Support Worker (Please tick as many that apply)			
	I would like housing assistance and/or; support		
	I would like support with my mental well-being and addictions		
	Do you need help with daily living activities?		
	I would like help to find study / employment		
	I would like help building whanau / hoa relationships		
	I need help accessing community / cultural services		
Are there any immediate concerns?	☐ Yes ☐ No		
If yes, please list			
I give Whare Tiaki Hauora permission to gain further information that will assist / support my wellness.			
Name			
Signature		Date	

Part 2
Referral Form

To be completed by Referring Agency
(Please print clearly)

Client Name			
Address			
Suburb		City	
Phone		Mobile	
D.O.B		NHI No	
Ethnicity			
Next of Kin		Phone	
Address			
Relationship			
Clinical Information			
Clinical Team			
Address			
Phone			
Keyworker Name			
Phone		Mobile	
Email			
Is this client currently under the MHA?	☐ Yes ☐ No		
If yes, which section?			
Who monitors?		Review Date	
How long has your agency, had contact with the client?			
How often do you currently see the client?			
Current Diagnosis			
Current Mental State *(Please give details of Past /Current Risk Behaviours)*			
(A) Aggressive behaviours			
(B) Alcohol behaviours			
(C) Drug behaviours			
(D) Suicidal behaviours			
Admission to hospital			
Date		Hospital	
Reason			
Date		Hospital	
Reason			

Are there any other health problems?	☐ Yes ☐ No		
If yes, please state			
How are these treated?			
Primary reasons for support			
	I would like housing assistance and/or; support		
	I would like support with my mental well-being and addictions		
	Do you need help with daily living activities?		
	I would like help to find study / employment		
	I would like help building whanau / hoa relationships		
	I need help accessing community / cultural services		
Immediate issues / concerns			
Please enclose the following information with this referral			
	Adult Risk Assessment and Management Plan		
	Relapse Prevention Partnership Plan		
	Co-ordinated Care Plan		
	Current Medication Prescribing Chart		
	Self-Referral Form – Part 1 (Whare Tiaki Hauora)		
Name		Designation	
Signature		Date	

Office Use Only

- ☐ Self-Referral form *(Part 1)* completed
- ☐ Referral form *(Part 2)* completed
- ☐ Adult Risk Assessment and Management Plan *(Attached)*
- ☐ Relapse Prevention Partnership Plan *(Attached)*
- ☐ Co-ordinated Care Plan *(Attached)*
- ☐ Current Medication Prescribing Chart *(Attached)*

Referral *(Please circle one)* **Approved** **Declined**

Reason for Declined

_____

_____

_____

_____

Entry Date: ____/____/____ Exit Date: ____/____/____