Mana o te Tangata Trust

REFERRAL FORM

Email completed form to: admin@manaotetangata.org.nz for both offices
Alternatively post to: PO Box 5569 Terrace End Palmerston North.

Client Information

Name: _____

Email: _____

Address: _____

City / Town: _____ Postcode: _____

NHI: _____ D.O.B. ____/____/____

Gender: _____ Age: _____

Ethnicity: _____/_____

Iwi (if applicable): _____

Home phone: _____ Mobile phone: _____

Next of Kin / Emergency Contact

Name: _____

Address: _____

City / Town: _____ Post Code: _____

Contact No:
Home: _____ Mobile: _____

Relationship: _____

Mental Health Condition	

Please see page 2 for regarding Mental Health Condition. What do we look for? How can we respond?

Substance Use / Abuse	

Please see page 2 for regarding Substance use / Abuse. What do we look for? How can we respond?

Physical issue / Disability	

Please see page 2 for regarding Physical issue / Disability. What do we look for? How can we respond?

Risks	

Please see page 2 for regarding Risks. What do we look for? How can we respond?

Reason for Support

- ☐ Adult Peer Support Mental Health & Addiction
- ☐ Kaupapa Maori Peer Support
- ☐ Youth Peer Support Mental Health & Addiction
- ☐ Information / Education Mental Health & Addiction / Workshops
- ☐ Day Activities & Healthy Living for people with Mental Health & Addictions

Please put (C) for Current and (H) for History if applicable Presenting Problems: Screening of Clinical Indicators (as indicated by client(s), family or referral source)

Mental Health Conditions

	Anti-Social Personality		Delusional Disorder		Psychosis
	Anxiety Disorder		Depression		Paranoid Schizophrenia
	Asperger's Syndrome		Dual Diagnosis AOD		Schizoaffective
	Autism		Obsessive Compulsive		Schizophrenia
	Bipolar Disorder		Personality Disorder		Other (please comment on page 1)
	Borderline Intelligence		Post Natal Psychosis		
	Borderline Personality		PTSD		

Substance

	Alcohol		LSD		Sedatives
	Amphetamine		MDMA		Solvents
	Benzodiazepine		Morphine		Tobacco
	Cannabis		Methadone		Other (please comment on page 1)
	Heroin		Methamphetamine		

Physical

	Arthritis		Epilepsy		Multiple Diagnosis
	Cardiovascular		Head Injury		Other (please comment on page 1)
	Asthma Med Mod Sev		Hearing Impaired		
	Diabetes Type 1		Hepatitis B		
	Diabetes Type 2		Hepatitis C		

Risks

	Allergies		Medical		Suicide
	Historical		Physical		Other (please comment on page 1)
	Legal / Environmental		Relapse (Mental Health)		

General Practitioner *(Contact Details)*

Practitioner Name: Email:

Address of Practice: Phone:

Organisation Referral

Service Referred from: Contact phone number:

Referred by (Name of Support worker / Key Worker / Practitioner):

Contact details DDI: Email:

Signature: Date: / /

I consent to my information being sent to Mana o te Tangata Trust to notify them of my consent to participate in this programme.

Signature:

Is this a Self-referral? ☐ YES ☐ NO

Clients Signature: **Date:** / /

OFFICE USE ONLY							
Referral Received		Allocated Kaimahi		Data Scanned		Client Contacted	
Data Entered		Date allocated		PDF Referral to ORG		Referral to	