Te Harakeke

Child, Adolescent and Family Service

Referral Form

Te Whatu Ora
Health New Zealand
Te Matau a Māui Hawke's Bay

Te Harakeke Contact Details

Email: mail478@hbdhb.govt.nz **Phone:** 06 878 8109 ext. 5848 **Address:** Private Bag 9014, Hastings 4156

Child, Adolescent & Family Services (CAFS) is a **Specialist Secondary Mental Health Service** that provides services to children and young people **0-18** years old who have moderate to severe mental health or addiction disorders.

RISK TO SELF, OTHERS OR FROM OTHERS

Are there any concerns regarding:

- Self-harm: ☐ Yes ☐ No
- Suicidal thoughts: ☐ Yes ☐ No
- Suicidal behaviour: ☐ Yes ☐ No

If yes please give a brief account:

What are the current safety measures in place?

1. If you have immediate concerns for the young person's safety, or the safety of others please dial 111.
2. If you have immediate concerns for the young person's mental health please dial **0800 112 334**
3. If you are concerned about the welfare and safety of the young person please call Oranga Tamariki (0508 326 459) or the police (111).

- Are parents/guardians of this young person aware of this referral ☐ Yes ☐ No
- Do you have parental consent to make the referral? ☐ Yes ☐ No
- Is the young person aware of this referral? ☐ Yes ☐ No
- Has the young person agreed to the referral? ☐ Yes ☐ No

Please note: This referral may be delayed if

1. This form is not complete,
2. This form not filled in adequately and/or
3. If there *is* **no parental consent gained (unless the adolescent is 16 or over)**.

If you require support to complete this referral please ring 06 8788109 ext 5848

Date _____

CLIENT DETAILS

Surname		NHI	
Legal Name/s		Preferred Name	
DOB		Age	
Address		Gender	
		Mobile	
Ethnicity		Languages Spoken	
Iwi Affiliations		Translator Needed	☐ Yes ☐ No
Religion		MHA Status	
Email			
GP & Practice			
School			

Would you like us to provide cultural support? _____

REFERRER'S DETAILS

Name _____ Organisation/role _____

Mobile _____ Address _____

Email _____ Relationship _____

CAREGIVER / GUARDIAN DETAILS

The Person / People We Contact to Arrange Appointments Are:

Name _____ Relationship _____

Address _____

Email _____

Home Ph _____ Work Ph _____ Mobile Ph _____

Name _____ Relationship _____

Address _____

Email _____

Home Ph _____ Work Ph _____ Mobile Ph _____

Cultural Supports Requested: _____

REASON FOR REFERRAL

What mental health concerns do you have for the child/young person?	
Other behaviours of concern?	
Is the above impacting on day-to-day functioning across 2 or more domains (e.g. home and school)?	
Have any particular triggers/events been identified as contributing factors?	
Is there any family/whanau history of mental health or addiction issues?	
Is there a history of adverse childhood experiences (abuse and/or neglect; witness of family violence? etc); other trauma history?	
Were there any Developmental/learning delays/challenges?	
Are there any factors you believe are contributing to the behaviours of concern being perpetuated?	
What are the strengths of the person/whānau being referred? What is working/ has worked in the past?	
Additional Information?	