Te Paepae Arahi Referral Form

First Name: Last Name:		Middle Name(s): Preferred Name:
Landline: Cell: Email:		Address (street and suburb):
Date Of Birth: Age:	Gender:	NHI Number:
Ethnicity:	Iwi:	
Additional Iwi and Hapū:		

Whānau Support/Next of Kin

Name: Relationship:

Phone:

Address:

Referred by:

☐ Self ☐ Whānau ☐ Other

Referrer details

Name: Service:

Phone:

Email:

Brief outline of issue(s):

Type of support wanted:

Te Paepae Arahi has a range of support workers: (male/female). If you have a culture or gender preference please let us know and we will match you with an appropriate support worker if possible. Please note that availability is dependent on caseload per staff member and cannot be guaranteed.

Preference: _____

GP/Doctor

Service Name:

Email: Doctor's Name:

Phone No: Address/Area:

Mental Health Clinician (if applicable and if different to referrer)

Service Name: Clinician Name:

Phone No: Address/Area:

School or Institute of Study (if currently or recently enrolled):

Housing type (private, rental, emergency, transitional housing or other, e.g. couch surfing, homeless). Number of whānau members in house: Adults: _____ Children: _____
Current legal issues (Corrections involvement, court orders, sentences) Key contact:
Key Agencies Involved:
Appointment Availability (days/times):
If available, the following Health Information would also be useful (If this info is already in attachments no need to replicate here).
Mental Health/Addictions (please include diagnosis and/or description) Current: Current Medications (dose and frequency): Historical:
Physical Health (please include diagnosis and/or description) Current: *Please list any health issues we should be aware of e.g. contagious or infectious issues, or issues affecting mobility.* Current Medications (dose and frequency): Historic:

Whānau Health Current: Historic:
Risk to self or others: self-harm, suicide, violence, drink driving, overdose, sharing needles, health etc.
I consent to this referral Tangata Whaiora (Client) Signature: Date: