

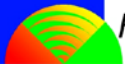
Phone: 09 836 2329
 Address: 49 Lincoln Road, Henderson
 414 B Glenfield Road, Glenfield

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Email: youthhub@healthwest.co.nz



REFERRAL to CHOICE's to WELLBEING PROGRAMME <input type="checkbox"/> <i>(Counselling or Mentoring)</i>		
REFERRAL to YOUTH (General Health) CLINIC: <input type="checkbox"/>		
REFERRAL to YOUNG DADS Programme <input type="checkbox"/>		
CLIENT DETAILS:		
MAIN CONTACT:		
Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caregiver <input type="checkbox"/> Other <input type="checkbox"/>		
Name:		
NHI: DOB: Age:	Relationship to Client:	
Address:		
Phone: HM:		
MB:		
WK:		
Email:		
ALTERNATIVE CONTACT:		
Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caregiver <input type="checkbox"/> Other <input type="checkbox"/>		
GP:		
Name:		
Gender:	Ethnicity:	
Relationship to Client:		
Phone: HM:		
Phone HM:	Mobile:	
MB:		
School:	Year:	
WK:		
Has the Young Person agreed to the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>Important Note: Referrals into the Youth Health Hub complete a triage process where referral information is shared with Marinoto, the Adult Mental Health Primary Care Liaison Nurse, CADS or Odyssey House to determine the most appropriate pathway. If accepted for the "Choices to Wellbeing" Primary Mental Health Programme contracted providers will also receive the referral form. Please ensure this is explained to the young person prior to consenting to the referral.</i>		
Are family members aware of this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is it okay to leave messages when client is not available?	Home: Yes <input type="checkbox"/> No <input type="checkbox"/> Mob: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is it okay to send correspondence to the client? <input type="checkbox"/> Yes <input type="checkbox"/> No		
REFERRER DETAILS:		
Name:	Organisation:	
Address:	Phone:	
	Fax:	
	Mobile:	
Relationship to client:	Email:	
Reason for referral (tick appropriate box):		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> General Youth Health	<input type="checkbox"/> Medication Oversight
<input type="checkbox"/> Grief / loss	<input type="checkbox"/> Primary Care Follow Up	<input type="checkbox"/> Sexual Health
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Chronic Health Care	<input type="checkbox"/> Transgender Health
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Personal / relationships	<input type="checkbox"/> Alcohol/Drugs
<input type="checkbox"/> Low Mood/ Depression	<input type="checkbox"/> Family Stressors	<input type="checkbox"/> Other



SUGGESTED INTERVENTION:

Family work

One to one

Group

MAIN PRESENTING ISSUE:

Other relevant information:

Family:

Medical/Health:

Current Medication:

Education:

Referrers Expectations:

Other Agencies/workers involved in Young Persons care:

Role and contact details

Referrer:

Signed name and designation:

Date:

Please attach other relevant information: previous assessments/treatment summaries, social work reports/relevant correspondence