

Te Paepae Ārahi Referral Form

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| **Personal Details Info.** | |
| First Name: | Middle Name(s): |
| Last Name: | Preferred Name: |
| Date of Birth: | Gender/Pronoun: |
| Age: | NHI Number *(If known)*: |
| Ethnicity: | Iwi: |
| Hapu: | Additional Iwi & Hapū: |
| **Contact Details Info.** | |
| Landline: | Address: |
| Mobile: | E-Mail: |

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| **Whānau/Next of Kin Support Info.** | |
| Name: | Relationship: |
| Contact Number: | Address: |

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| **Referrer Info.** | | | |
| Self | Whānau/Family | | Other |
| Referrer Name *(if not self)*: | | Service Name: | |
| Landline: | | Mobile: | |
| Email: | | | |

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| **Support Needs** | |
| Te Paepae Ārahi Services: | |
| Pākeke (Adult) Wellbeing Support | Rangatahi (Youth) Wellbeing Support |
| Alcohol & Other Drug (AOD) Support | Impaired Drivers Awareness Course (IDAC) |
| Ngā Kete Aronui | Kaumātua (Elders) Group |
| Te Rōpu Tāne (Men’s Group) | Te Whāinga Whirikoka (Women’s Group) |
| Access And Choice |  |
| Brief description of current issue(s): | |
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| Type of support wanted: | |
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| Support Preference:  Te Paepae Arahi has a range of support workers: (male/female). If you have a 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 current capacity and cannot be guaranteed.* | |
| Preference: Male  Female | |
| Appointment Availability (days/times): | |

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| **GP/Doctors Info.** | | |
| Service/Clinic Name: | | Doctors Name: |
| Phone Number: | | E-Mail: |
| Address/Area: | | |
| **Mental Health Clinician** *(If applicable or different from referrer)* | | |
| Service Name: | Clinician Name: | |
| Phone Number: | Address/Area: | |

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| **Housing** | |
| Current Housing Situation: *(private, rental, emergency, transitional housing or other, e.g., couch surfing, homeless)* | |
| Number of whānau/people living in the house | |
| Number of Adults: | Number of Children: |

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| **Current Legal Issues *(Corrections involvement, court orders, sentences)*** | |
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| Key Contact Name: | Phone Number: |
| Email: | |

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| **Key Agencies** *involved with your care* |
| 1. |
| 2. |
| 3. |

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| **Additional Health Info.** |
| If available, the following Health Information would also be useful.  (If this information is attached to this referral this is not applicable) |
| Current Medications *(Dose & Frequency)* |
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| Historical Issues: |
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| **Risk** | |
| Are you a Risk to yourself or others?: | |
| Yes | No |
| If so, please describe here: | |
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| **PRIMHD Review Info.** *(Ministry Of Health Data Collection)* | | | | | | |
| Current Employment | | | Wellness Plan | | | |
| Paid | Voluntary | None | Yes | No | | I’m Unsure |
| Housing | | | Education | | | |
| Financially Independent *Home Owner, Renting* | | | Currently Training | | Not at present | |
| Temporary Accommodation | | |
| Funded/Partially Funded by Mental Health Services | | | NZQA Recognised organisation | | Other | |
| Homeless | | |

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| **Additional Info.** *(Please add any relevant information that may help with your referral)* |
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| **Consent** *(If completing on behalf of someone else, please ensure they have consented to this referral)* |
| Tangata Whaiora (Client) Signature: |
| Date: |