

Referral Form - Mental Health Support Service

**Referrer Details:**

*(If Central Lakes Community MHT (Dunstan or QT), attach triage assessment & consent to liaise in lieu of completing referral form)*

|  |  |
| --- | --- |
| Referred By: | Date: |
| Agency/Service: | Phone: |
| Email: | Client consent for referral: Verbal or attached written? |

**Service User Details:**

|  |  |
| --- | --- |
| Name: | DOB: |
| Address: | Phone: |
| Ethnicity: NHI#:  | Emergency Contact Person Details (name, relationship to service user, phone number):  |

|  |
| --- |
| Is the person currently under specialist psychiatric care? Yes/No |
| **Cultural Needs (Interpreter, religion, spiritual beliefs, health needs, support person, sign language, etc.) (specify):** |
| **Other agencies involved:**  |

**Current Presenting Issues – Reason for Referral and Potential Areas for Support:**

**Summary and Brief History:**

*Psychiatric History, Family History, Forensic, Drugs & Alcohol, Relevant Medical Conditions, Diagnoses etc*

**Current or Historic Risk:**

*Risk to self, risk to others, vulnerabilities*

**Medications:**

**Plan on completion of support with CLFS: Referrer to highlight an option please**

|  |  |  |  |
| --- | --- | --- | --- |
| Copy of closure to be emailed to referrer  | Person to be directed back to GP for follow up | Person to be directed back to Central Lakes Community Mental Health Team | Other (please specify) |

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Email referral to - mhsupport@clfs.co.nz.

Referrals can also be directed to the duty person on 0508 500655