Te Oranganui
57 Campbell Street, Whanganui
Phone: 06 349 0007 Fax: 06 345 6168

KARANGA TUATAHI – REFERRAL FORM

Whānau being referred:	
Name:	**Address:** **Phone:**
NHI:_______________ **D.O.B:** ____/____/____ **Gender:** ____________ **Age:** ______________	**Ethnicity:** **Religion:**
Whānau Support / Primary Caregiver:	
Name:________________________________ **Address:** ______________________________	**Contact No:** ______________________________ **Relationship to Referral:**_________________________
Name:________________________________ **Address:** ______________________________	**Contact No:** ______________________________ **Relationship to Referral:**_________________________
Referral Source:	
Name: ________________________________ **Role/Service:**________________________________ **Contact Details i.e. mailing address, email address, phone** ____ ____	
Reason for Referral:	

Any other services involved: **i.e. CYFS, Probation, Community Mental Health, Jigsaw, Family Works, WINZ, Housing NZ, Living Without Violence, Tupoho Social Services, Women's Refuge**			
Name:	**Service:**	**Address:**	**Contact:**

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Presenting Concerns:							
Risk Alert – Screening of clinical indicators (as indicated by client, whānau or referrer) Please tick if applicable							
	Harm to self:		Suicidal		Self Injury *(Specify)*		
	Harm to others:		Emotional		Physical		Sexual
	Medication Issues:		Side effects		Non-adherence		
	Other *(specify)*						
	VICTIMISATION HISTORY:		Trauma Emotional		Physical		Sexual
	Elder Abuse		Serious Medical Concerns		Issues AOD		Self Care (ADL's)
	Partner Abuse		Legal Status Informal		Mental Health Act		Child Abuse
	Child/Adolescent Concerns	**Other** *(Specify)*					
	SOCIAL DIFFICULTIES:		Housing		Financial		Education
	Employment Issues	**Other** *(specify)*					
	RELATIONSHIP DIFFICULTIES:		Partner		Children		Family
	Other *(specify)*						
	PSYCHOSIS:		Delusions		Hallucinations		Negative Symptoms
	Abnormal through process		Unusual behaviour *(specify)*				
Present Medication:							
Any challenges: e.g. young parent facing challenges, lack of positive support networks, low income, transiency, SUDI factors, difficulty attending appointments							
Current living situation:							

DATE:____/____/____ **SIGNED:** ____

I/We consent to have a Te Oranganui representative visit and answer questions about Te Oranganui Iwi Health Services. I understand that my information and details are strictly confidential and that I am not obliged to enrol with the organisation.

NAME: ___________________________________ **SIGNED:** __________________________________