POUTIRI TRUST : **REFERRAL**

KIRITAKI CLIENT REFERRAL FORM F 605-6 V3.0

Please send this referral form to **referral@poutiri.org.** All new referrals will be considered within 3 working days, and you can expect to hear back from our intake coordinator.

CLIENT REFERRAL DETAILS: *(Please ensure all details are filled in)*

Date of Referral: .... NHI (if known):.................... GP: ....

Clients name: ....

Date of Birth:............................... NZ Citizen/Resident/CSC: ....

Address: ....

....

Phone Number:.................................... Alternative contact number: ....

Gender: Male ☐ Female ☐ Other ☐

Interpreter needed? Yes ☐ No ☐ If YES, what language? ....

Ethnicity:... Iwi/Hapū (if known):...

Reason for referral: (Please complete further information on page 2)

....

....

....

NEXT OF KIN/EMERGENCY CONTACT : (please provide the following information if known):

NB: This section must be completed for all clients under 16 years of age

Next of Kin: .... Relationship:...

Next of Kin Phone:.. Alternative contact details: ....

REFERRER DETAILS :

Referral Type: Self ☐ Whānau ☐ External ☐ Internal ☐

Referrer Name: .... Organisation: ....

Relationship: .... Email:..

Work Phone: .... Alternative Phone:...

Please complete further information on page 2

BELOW HERE FOR OFFICE USE ONLY

FOR COMPLETION BY POUTIRI KAIMAHI:

Sent to intake Y ☐ Initial/Date:......................... **Entered to CMS** Y ☐ Initial/Date: ....

INTAKE

Referral Accepted Y ☐ N ☐ Designated Key Worker:......................... **RP Updated** Y ☐ Initial/Date:.....................

Comments/Reason for Decline:

....

Accepted to:

- ☐ Dual Diagnosis MHAD14C
- ☐ Whanau Support MHK59E
- ☐ ICAY (Non-Clinical) MHD148D
- ☐ ICAY (Clinical) MHI44C
- ☐ Mataora Counselling
- ☐ Pouwhenua MAOR0110
- ☐ Maara Kai MAOR0117
- ☐ Whānau Fitness MAOR0117
- ☐ MSD Piringa
- ☐ Māmā Maia
- ☐ Rongoā Mirimiri
- ☐ Mataora Moko
- ☐ Mataora Ngahere
- ☐ HIP/ Health Coach
- ☐ Whaioranga

Completed referral uploaded to file Y ☐ Initial/Date: ....

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DETAILS OF EMPLOYMENT / TRAINING :

Paid Employment:	Yes ☐	No ☐	Full-time ☐	Part-time ☐	Casual ☐
Voluntary Work:	Yes ☐	No ☐	Full-time ☐	Part-time ☐	Casual ☐
Training/Study:	Yes ☐	No ☐	Full-time ☐	Part-time ☐	Other ☐

Additional Details/Comments:

....

....

....

SCHOOL DETAILS IF APPLICABLE:

School Name:... Current School Year:.......................

Please provide the following information (attach any supporting documentation):

Overview of situation:

....

....

....

....

RISK ASSESSMENT :

Completed by: Self ☐ Referrer ☐ Low ☐ Medium ☐ High ☐

Details as appropriate:

....

....

....

MEDICATION/HEALTH:

Please include any known allergies including to food and/or medication:

....

....

....

Any further details or information regarding additional needs that will support consideration of referral to most appropriate service(s):

....

....

....

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