HealthWEST

YOUTH HEALTH HUB REFERRAL FORM

Phone: 09 836 2329 **Fax: 09 836 2328**
Address: 49 Lincoln Road, Henderson
414 B Glenfield Road, Glenfield **Email: youthhub@healthwest.co.nz**

REFERRAL to CHOICE's to WELLBEING PROGRAMME ☐		
REFERRAL to YOUTH (General Health) CLINIC: ☐		
REFERRAL to YOUNG DADS Programme ☐		
CLIENT DETAILS:		**MAIN CONTACT:**
		Parent ☐ **Guardian** ☐ **Caregiver** ☐ **Other** ☐
Name:		**Name:**
NHI: **DOB:** **Age:**		**Relationship to Client:**
Address:		**Phone: HM:**
		MB: :
		WK:
Email:		**ALTERNATIVE CONTACT:**
		Parent ☐ **Guardian** ☐ **Caregiver** ☐ **Other** ☐
GP:		**Name:**
Gender:	**Ethnicity:**	**Relationship to Client:**
		Phone: HM:
Phone HM:	**Mobile:**	**MB:**
School:	**Year:**	**WK:**

Has the Young Person agreed to the referral? ☐ **Yes** ☐ **No**

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.*

Are family members aware of this referral? ☐ **Yes** ☐ **No**

Is it okay to leave messages when client is not available? **Home:** ☐ **Yes** ☐ **No** **Mob:** ☐ **Yes** ☐ **No**

Is it okay to send correspondence to the client? ☐ **Yes** ☐ **No**

REFERRER DETAILS:	
Name:	**Organisation:**
Address	**Phone:**
	Fax:
	Mobile:
Relationship to client:	**Email:**

Reason for referral (tick appropriate box):

☐ Anxiety	☐ General Youth Health	☐ Medication Oversight
☐ Grief / loss	☐ Primary Care Follow Up	☐ Sexual Health
☐ Mental Health	☐ Chronic Health Care	☐ Transgender Health
☐ Personal / relationships	☐ Alcohol/Drugs	
☐ Low Mood/ Depression	☐ Family Stressors	☐ Other (please specify)

SUGGESTED INTERVENTION:

☐ **Family work** ☐ **One to one** ☐ **Group**

PRESENTING ISSUES:

Other relevant information:

Family:

Medical/Health:

Current Medication:

Education:

Referrers Expectations:

Other Agencies/workers involved in Young Persons care:

Referrer:

Signed name and designation: **Date:**

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