YOUTH HEALTH HUB REFERRAL FORM

Phone: 09 836 2329 / 0800 562 023
OPTION 1 – COUNSELLING OPTION 2 – CLINIC
Address: 49 Lincoln Road, Henderson
414A Glenfield Road, Glenfield

For Counselling/Mentoring/Groups
Email: youthhub@healthwest.co.nz

For Youth Clinic
Email: youthclinic@healthwest.co.nz

REFERRAL to CHOICE's to WELLBEING PROGRAMME: ☐ **COUNSELLING OR MENTORING GROUPS**			
REFERRAL to YOUTH HEALTH CLINIC: ☐			
CLIENT DETAILS:			**MAIN CONTACT:**
			Parent ☐ Guardian ☐ Caregiver ☐ Other ☐
Name:			**Name:**
NHI:	**DOB:**	**Age:**	**Relationship to Client:**
Address:			**Phone:**
			Email:
Phone:			
Email:			**ALTERNATIVE CONTACT:**
Gender:			**Parent ☐ Guardian ☐ Caregiver ☐ Other ☐**
Ethnicity:			**Name:**
Iwi			**Relationship to Client:**
GP:			**Phone:**
School:	**Year:**		**Email:**

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 the parents/legal guardians consenting to this referral? (under 16 year old clients)
Yes ☐ **No ☐**

Is it okay to leave messages when client is not available? (Call or Text) **Yes ☐** **No ☐**

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

REFERRER DETAILS:	
Name:	**Organisation Details:**
Phone:	
Email:	
	Date of Referral:
Relationship to Client:	

Reason for referral (tick appropriate box):

☐ Anxiety	☐ General Youth Health	☐ Medication Oversight	☐ Self Harm
☐ Grief / Loss	☐ Primary Care Follow Up	☐ Sexual Health	☐ Suicidal Ideation
☐ Anger	☐ Chronic Health Care	☐ Transgender Health	☐ Other (please specify)
☐ Personal / Relationships	☐ Alcohol/Drugs	☐ Trauma	_____
☐ Low Mood / Depression	☐ Family Stressors		

SUGGESTED INTERVENTION:

☐ **Family Work** ☐ **Counselling** ☐ **Mentoring / Youth Work** ☐ **Group**

Presenting Worries:

Family (who lives with you):

Medical Conditions:

Current Medications:

Education (are you studying/at school?):

Referrers Expectations:

Current Agencies/Workers Involved:

Preferred Appointment Days/Times:

Is there anything else you would like us to know?

Once this form has been completed, please send to the appropriate service:
Youth Clinic – youthclinic@healthwest.co.nz (General Health)
Choices to Wellbeing – youthhub@healthwest.co.nz (Mental Health, Mentoring, Groups)

Please attach any other relevant information you feel may be helpful.