# MENTAL HEALTH & ADDICTIONS REFERRAL FORM
## HAWKES BAY

**NHI:** ____________________________ **Date:** ____________________

***required field***

* **First Name**: ______________________________ ***Surname**: ________________________________

Preferred Name: ___________________________ *Gender: _________________________________

*DOB: ________________ Ethnicity: _____________________ Iwi: _________________________

*Address: ______________________________________________________________________________

*Phone contact: Hm: ___________________ Mobile: ___________________________________

Email: _____________________________________ *Preferred contact method:❑ Phone ❑ Email

**Referring Agency**: ____________________________________________________________________

Keyworker/Referrer Name:_______________________________________________________________

Referrer Phone contact: _____________________ Email: ______________________________

Referrer Address: _______________________________________________________________________

**Next of Kin & Contact Details**: ____________________________________________________________

_____________________________________________________________________________________

Are Next of Kin/Family/Whanau aware of and support referral? ❑ Yes | ❑ No
Is the consumer aware of and agrees to the referral? ❑ Yes | ❑ No

**GP**: ____________________________________________________________________________________

**Substances of choice?**

| Meth/amphetamines | Cannabis | Alcohol | Opiates | Solvents | Synthetic Highs |
|---|---|---|---|---|---|
| Benzodiazepines | LSD/Hallucinogens | Tobacco | IV Drug Use | Other: ______________________ | |

**Any mental health issues (please state):** ____________________________________________

_____________________________________________________________________________________

**Any Medical concerns or allergies (please state)**: ________________________________________

_____________________________________________________________________________________

**Does the consumer have..** Children aged under 14 in your care? ❑ Yes | ❑ No
Any pending charges with the courts? ❑ Yes | ❑ No
Difficulties in reading/writing/memory? ❑ Yes | ❑ No

**Services to be considered for assessment**:

❑ Support Groups | ❑ Residential Programme | ❑ Community Day Programme

**Where did you find out about our service?** _________________________________________

**Any other comments?** ______________________________________________________________

_____________________________________________________________________________________

**Please send referral to:** MASH Trust | PO Box 549 | Hastings
Phone: 06 870 4265 or 0800 6274 878 | Referral Fax: 06 870 3913
Referral Email: hbreferral@mashtrust.org.nz