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| **MH&AS SELF REFERRAL FROM** |

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| ***Once you have completed form please email to***  mhtriage@lakesdhb.govt.nz ***and some one will make contact with you***  |

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| --- | --- | --- | --- |
| **Date:** |  | **Urgency:** |  |

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| **DEMOGRAPHIC INFORMATION** |
| **NHI:** |  | (if known) | **DOB:** |  |
| **Gender:** |  |
| **Surname:** |  | **Forename(s):** |  |
| **Address:** |  |
| **Phone:** |  | **Mobile:** |  |
| **Email:** |  |

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| **Preferred method of contact:** | Select a Method | **Specify:** |  |
| **Ethnicity:** | Select Ethnicity | **Specify:** |  |
| **Interpreter required:** |  | **Specify:** | Select Language |

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| **general practitioner & pharmacy** |
| **General Practitioner:** | Select General Practitioner | **Specify:** |  |
| **Surgery:** | Select Surgery | **Specify:** |  |
| **Pharmacy:** | Select Pharmacy | **Specify:** |  |

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| **reason for referral** |
| Enter Text Here |
| **Have you previously been a client of Mental Health & Addiction Services?** |
|  |  |
| **Are you involved with any other agencies or programmes?** |
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| **current medications** |
| Enter Text Here |

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| **any other information you may think may be important** |
| Enter Text Here |