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

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| ***Once you have completed form please email to***  [CMH&ASTaupo@lakesdhb.govt.nz](mailto:CMH&ASTaupo@lakesdhb.govt.nz) ***and someone will make contact with you*** |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 |

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