Family Mental Health Service
3 Wickliffe Street
Mosgiel 9024
Ph: 03 489 3728

Date:.........................

Name:...

Date of Birth: .... **National Number:** ....

Address: ....**Phone Number:** ....

Ethnicity:.. **Iwi:** .... **Cell Phone:**................................

Gender: .... **Email:** ....

Personal Representative: .... **Relationship:** ....

Address: .... **Phone:** ....

GP Name: ....**GP Phone:** ....

GP Address: ....

Reason for Referral/Follow up requested:

Summary and Brief History:

Psychiatric history, Family psych history, Forensic, Drug & alcohol, relevant medical conditions, diagnosis

Current Interventions:

Medication , services provided, ODHB case manager if relevant, other referrals

Safety Issues:

Risk to self or others, vulnerability

Social situation:

Accommodation, financial, dependant care responsibilities, significant others

Support services and other agencies:

NGOs, School, Statutory agencies, Community supports

Consumers Expectations and comments:

Client Consent: YES / NO Signature: ________________________

Note*: if under 16 yrs, are parent/s aware of referral* ☐*Yes* ☐*No*

Name of referring person:	**Designation:**
Agency:	**Date of Referral:**
Contact Number:	**Signature:**

Email to: fmhsadmin@wellsouth.org.nz