**RASNZ Community Clinical Team Self-Referral Form (Adult)**

*Please assist us in providing all information requested in this electronic form.*

*Print completed form and Fax referral to (09) 620 2542 or E-Mail to* *enquiry@rasnz.co.nz*

*On receiving a completed form, RASNZ will contact you within 2 weeks to further discuss your referral*

**Client Details**

|  |  |  |
| --- | --- | --- |
| **Referral Date** |  |  |
| **Surname**  |  | **Given Names** |  |
| **NHI** |  | **Date of Birth** |  |
| **Age** |  | **Nationality** |  |
| **Gender** | Choose an item | **Date of Arrival to NZ** |  |
| **Refugee Status** |[ ]  Quota Refugee |[ ]  Asylum Seeker |[ ]  Convention Refugee |[ ]  Family Reunification |
| **Address** |  |
| **Phone Number** |  | **Mobile Number** |  |
| **Preferred Language** |  | **Interpreter Required** | Choose an item |

**General Practitioner Details** *(GP details are needed to process the referral)*

|  |  |
| --- | --- |
| **GP Name** |  |
| **Address** |  |
| **Email** |  | **Phone** |  | **Fax** |  |

**Current Presenting Issues of Concern***(Select all that are applicable)*

|  |
| --- |
| Difficulty sleeping  |[ ]
| Appetite Problems |[ ]
| Experiencing worrying thoughts most of the time  |[ ]
| Feeling sad most of the time  |[ ]
| Feeling stressed and unable to cope most of the time  |[ ]
| Constantly remembering past traumas  |[ ]
| Relationship difficulties  |[ ]
| Feeling isolated  |[ ]
| Feeling hopeless  |[ ]
| Body pains  |[ ]
| Other |[ ]
| If you have selected other, please describe: |
| For how long have these issues been a problem: |
| Impact of these issues on the client’s activities of daily living | Choose an item |

**Have you received any treatment in New Zealand such as medication and/or counselling for your above problems?**

|  |
| --- |
|  |

**If yes, which organization provided you this service?**

|  |
| --- |
|  |

I give RASNZ consent to contact the above stated organization for release of my treatment case notes.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

**Client Consent**

|  |  |  |
| --- | --- | --- |
| I |  | agree to this referral. |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

**Office use only:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date Received** | **Scan & Save** | **Screening Allocated To** | **Date of Screening** | **Letter sent to Referrer** | **Letter sent to Client** |
|  |  |  |  |  |  |