**RASNZ Community Clinical Team 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*

**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 | | |

**Referrer Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** |  | **Position** | |  | | |
| **Agency** |  | | | | | |
| **Address** |  | | | | | |
| **Email** |  | **Phone** |  | | **Fax** |  |

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

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

**Current Presenting Issues of Concern***(Describe client’s most recent issues e.g. nightmares, sleeping difficulties, low mood, worry, loss of memory, body pain, etc. and time of commencement)*

|  |  |
| --- | --- |
|  | |
| For how long have these issues been a problem: | |
| Impact of these issues on the client’s activities of daily living | Choose an item |

**Reason for Referral**

|  |
| --- |
|  |

**Risk Assessment**

*(Risk of harm to self or others)*

|  |  |
| --- | --- |
| Reported history of self-harm | Choose an item |
| Current thoughts of self-harm | Choose an item |
| Disclosed history or current thoughts of harm to others | Choose an item |
| *Give details of historical / current risk if any:* | |

**Current Medication**

|  |
| --- |
|  |

**Other Relevant Information***(Please provide relevant background information, including torture and trauma history, and past medical conditions)*

|  |
| --- |
|  |

**Client Consent**

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

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

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

**Office use only:**

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