**RASNZ Regional Mobile 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** |  | **NHI** |  |
| **Surname / Family Name**  |  | **Given Names** |  |
| **Pronouns** |  | **Date of Birth** |  |
| **Age** |  | **Nationality** |  |
| **Gender** | Choose an item | **Date arrived NZ** |  |
| **Refugee Status** |[ ]  Quota Refugee |[ ]  Asylum Seeker |[ ]  Convention Refugee |[ ]  Family Reunification |
| **Original settlement location in NZ** |  | **Date moved to Auckland** |  |
| **Current Address** |  |
| **Phone Number** |  | **Mobile Number** |  |
| **Email Address** |  | **Okay to leave messages?** | Choose an item. |
| **Emergency contact name** |  | **Emergency contact 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)*

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|  |
| 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**

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| --- |
|  |

**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)*

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**Client Consent**

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

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

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