TE PAEPAE ĀRAHI

Te Paepae Ārahi Referral Form

Personal Details Info.	
First Name:	Middle Name(s):
Last Name:	Preferred Name:
Date of Birth:	Gender/Pronoun:
Age:	NHI Number *(If known)*:
Ethnicity:	Iwi:
Hapu:	Additional Iwi & Hapū:
Contact Details Info.	
Landline:	Address:
Mobile:	E-Mail:

Whānau/Next of Kin Support Info.	
Name:	Relationship:
Contact Number:	Address:

Referrer Info.		
Self ☐	Whānau/Family ☐	Other ☐
Referrer Name *(if not self)*:		Service Name:
Landline:		Mobile:
Email:		

Support Needs	
Te Paepae Ārahi Services:	
Pākeke (Adult) Wellbeing Support ☐	Rangatahi (Youth) Wellbeing Support ☐
Alcohol & Other Drug (AOD) Support ☐	Impaired Drivers Awareness Course (IDAC) ☐
Ngā Kete Aronui ☐	Kaumātua (Elders) Group ☐
Te Rōpu Tāne (Men's Group) ☐	Te Whāinga Whirikoka (Women's Group) ☐
Access And Choice ☐	
Brief description of current issue(s):	
Type of support wanted:	
Support Preference: Te Paepae Arahi has a range of support workers: (male/female). If you have a gender preference, please let us know and we will match you with an appropriate support worker if possible. **Please note that availability is dependent on current capacity and cannot be guaranteed.*	
Preference: Male ☐ Female ☐	
Appointment Availability (days/times):	

GP/Doctors Info.	
Service/Clinic Name:	Doctors Name:
Phone Number:	E-Mail:
Address/Area:	
Mental Health Clinician *(If applicable or different from referrer)*	
Service Name:	Clinician Name:
Phone Number:	Address/Area:

Housing	
Current Housing Situation: *(private, rental, emergency, transitional housing or other, e.g., couch surfing, homeless)*	
Number of whānau/people living in the house	
Number of Adults:	Number of Children:

Current Legal Issues *(Corrections involvement, court orders, sentences)*	
Key Contact Name:	Phone Number:
Email:	

Key Agencies *involved with your care*
1.
2.
3.

Additional Health Info.
If available, the following Health Information would also be useful. (If this information is attached to this referral this is not applicable)
Current Medications *(Dose & Frequency)*
Historical Issues:

Risk	
Are you a Risk to yourself or others?:	
Yes ☐	No ☐
If so, please describe here:	

PRIMHD Review Info. *(Ministry Of Health Data Collection)*					
Current Employment			Wellness Plan		
Paid ☐	Voluntary ☐	None ☐	Yes ☐	No ☐	I'm Unsure ☐
Housing			Education		
Financially Independent *Home Owner, Renting* ☐			Currently Training ☐		Not at present ☐
Temporary Accommodation ☐					
Funded/Partially Funded by Mental Health Services ☐			NZQA Recognised organisation ☐		Other ☐
Homeless ☐					

Additional Info. *(Please add any relevant information that may help with your referral)*

Consent *(If completing on behalf of someone else, please ensure they have consented to this referral)*
Tangata Whaiora (Client) Signature:
Date: