[](http://www.equip.net.nz/)Equip Referral

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Mental-Health-Awareness □ Community Support Hours Caring%20Handshake □ Family / Whānau support

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \***Date:** |  | | | | | | | | | | |
| \***Name:** |  | | **NHI:** | | |  | | **Gender:** | | | Male / Female |
| \***Date of Birth:** |  | | \***Ethnicity** | | |  | | **Iwi:** | | |  |
| \***Current Address:** |  | | | | | | | \***Phone:** | | |  |
| **Current Living Situation:** □Living with others □Boarding house  □Homeless □Living alone □Living with family / whānau □Own home | | | | | | | Currently smoking Yes □ No □  (within the last 30 days) | | | | |
| **Current Employment status:** Working yes □ No □ If **Yes**: Full time □ Part time □ | | | | | | | | | **Previous work position held:** | | |
| **Next of Kin:** |  | | | **Next of Kin Phone No:** | | | | |  | | |
| **Keyworker/ CMHS:** |  | | | **Phone/ Email:** | | | | |  | | |
| **Psychiatrist:** |  | | | **Current Legal Status:** | | | | |  | | |
| **Service Co-ord.:** |  | | | **Phone/ Email:** | | | | |  | | |
| **Current GP:** |  | | | **Phone:** | | | | |  | | |
|  |  | | | **CSW Gender preference** | | | | |  | | |
| Please tick the type of support you are applying for: *(more than one may be applicable)* | | | | | | | | | | | |
| Finding accommodation □ | | Support with Daily Living □  Budgeting □ | | | Education / Training □ | | | | | Job Finding / Work / □  employment | |
| Medication □ | | Community Health Support □  Clinical / Non Clinical | | | Being social with others □  (Groups / Activities) | | | | | Leisure Activities □ | |
| Support with my wellness □ | | Keeping me safe □ | | | Interacting with other □  people and environments | | | | | Personal Health □  conditions | |
| Quitting / □  Reducing smoking | | Alcohol and / or □  Drug use | | | Problem Gambling □ | | | | | ACC eligible conditions □  (e.g. head injury) | |
| Involvement with legal □  system | | Family / whānau and □  support people | | | My Culture □ | | | | | My Spirituality □ | |
| Age related needs □ | | Need Interpreter? yes □No□  Language Preference  ………………………………… | | | Parenting □ | | | | | Other areas □  Please state…………………… | |

\*I (name)………………………………….....consent to this referral yes □ No □ \*Signature……………………………….

\*I consent to the access of information to support this referral yes □ No □

\*Name of referrer………………………………………………………………\*Signature of referrer………………………………………..

|  |  |
| --- | --- |
| **Attached Information (√ Tick please)** | |
| **Adult History / Summary of situation** |  |
| **Current Risk Assessment / Safety Plan:** |  |
| **Other Relevant Assessments:** |  | Eg Forensic, Psychological, Occupational Therapy, Cultural, AOD, etc |
| **Early Warning Signs / Relapse Prevention Plan:** |  |
| **SNAP** |  |
| **Other information (please state)** |  |