Equip Referral

 550 East Coast Road, Mairangi Bay, Auckland Ph: 09 4770338 Fax: 4795353      front.desk@equip.net.nz

 □ Community Support Hours  □ Family / Whānau support

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| \***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………………………………………..

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| **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)** |  |