New Start Service

E | refer@wellbeingnc.org.nz

REFERRAL FORM

PERSONAL INFORMATION

(Must be as appears on birth certificate)

Birth Name: _____ Date of Referral: _____

Address: _____ NHI: _____

Best Contact: _____ Ethnicity: _____

D.O.B: _____ Age: _____

Gender: _____ Does rangatahi consent to engaging with the service? ☐

All rangatahi under 16 must have consent from a parent or caregiver.

PARENT / CAREGIVER

Name: _____ Relationship: _____

Address: _____

Best Contact: _____ Email: _____

Does client live with caregiver? ☐ Caregivers Signature: _____ Verbal Consent: ☐

REFERRER

Name: _____ Agency: _____

Agency Address: _____

Phone: _____ Mobile: _____

Please ensure that the client and their guardian (if under 16) are aware of this referral.

We are unable to accept referrals without this consent.

If you have any questions please contact the service, we are able to provide advice and guidance.

REFERRER'S SIGNATURE :

Signed: _____ Date: _____

All fields must be completed

PRESENTING CONCERNS:

ALCOHOL AND OTHER DRUGS:

LIVING SITUATION:

RELEVANT CHARGES / ALTERNATIVE ACTION PLANS / PROBATION:

RELEVANT MENTAL HEALTH CONCERNS / RISKS:

Past or current: Self Harm ☐ Suicide ☐

History of:

Current Concerns:

RISK FACTORS FOR CLIENT OR CLINICIAN - *(Family Violence, Aggression, Unsafe Environment)*:

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OTHER AGENCIES INVOLVED:

Name:	Organisation:	Contact Number:
Name:	Organisation:	Contact Number:
Name:	Organisation:	Contact Number:
Name:	Organisation:	Contact Number:
Name:	Organisation:	Contact Number:

PLEASE SEND REFERRALS TO:

Email: refer@wellbeingnc.org.nz

Postal: Community Wellbeing North Canterbury Trust
New Start Service
PO Box 409
Rangiora, 7440
NORTH CANTERBURY