WCLT REFERRAL FORM

<table>
<tr><td colspan="3">Entry to Service Criteria
- Identifies or has a vulnerability of social isolation, or a Mental Illness and/or diagnosis.
- Over the age of 18 years old (An Exception for: MMHM referrals)
- Live within the Whanganui-Rangitikei Region

Please note: Acceptance of referral is dependent on the WCLT risk assessment process</td></tr>
<tr><td colspan="3">Date of Referral:</td></tr>
<tr><td rowspan="4">Person Details</td><td>Surname:</td><td>Given Name:</td></tr>
<tr><td>Address:

Phone Number:</td><td>DOB:

Your Ethnicity:

Your Gender:</td></tr>
<tr><td>Next of Kin:

Relationship:

Address:

Phone Number:</td><td>NHI:

GP/Doctor:

Phone Number:

Pharmacy:</td></tr>
<tr><td colspan="2">Consent</td></tr>
</table>

I _____ give my permission to Whanganui Community Living Trust to access and share information with other people involved in my support, while I am receiving services from this Trust.

I understand this information is confidential and my rights under the Privacy Act (1993) will be respected.

I understand that accessing or sharing information may involve discussions, phone calls and letters to other health and wellbeing practitioners, including but not limited to my General Practitioner, Psychiatrist, and Community Mental Health Service. The Trust will use this information to better understand how to support me.

This consent also specifically covers permission to view any current Section Papers (such as Compulsory Treatment Orders) that may have been issued through the Community Mental Health Service under The Mental Health Act 1992. The Trust will gain your consent prior to accessing your information.

Failure to give your consent may result in the Trust being unable to support you. You can withdraw your consent at any time.

Name:

Signature: …… Date: ……

PLEASE NOTE THAT OTHER SERVICES MAY REQUIRE YOU TO SIGN A SEPARATE CONSENT FORM FOR THEIR RECORDS.

Request for Services		
Support Services Type: Community Social Support Services (Any Clinician or self-referral can refer) ☐ Enhanced Mobile Services ☐ MMHM Maternal Mental Health Mothers (CMH/NASC Referral Only)(POC) ☐ Packages of Care ☐		
External Referrer Details		
Team Details	**Team:**	
	Referring Clinician or Key Worker:	
	Psychiatrist:	
	Other(s)	
EMS Enhanced Mobile Services – Purposes Only:		
Pharmacy:		
MED Support:	BD ☐ TDS ☐ MANE ☐ NOCTE ☐ or DEPO Support ☐	
Med Support Days:	**MON** ☐ **TUE** ☐ **WED** ☐ **THUR** ☐ **FRI** ☐ **SAT** ☐ **SUN** ☐ **Other:**	
MED Collection Day:		
Legal Status		
MHA Status:	**Section:** **Review Date:**	**Responsible Clinician:**
Presentation and Plan		
Presentation:		
Risk Factors:		
Specific goals of application:		
Proposed exit plan:		
Potential barriers to discharge:		

Details			
Diagnosis:			
Early Warning Signs:			
Relapse Prevention Strategies:			
Physical Health Issues:			
Identified Unmet Needs Requiring Support:			
Proposed services:			
Expected outcomes Support services:			
Discussed and agreed with service user/tangata whaiora:	Yes/No	**Family/Whanau participation:**	Yes/No
Start Date:	**Review Date:**		
Estimated Discharge Date:			

Forms Attached		
Current Risk Management Plan		**Referral Accepted/Declined/Waitlist**
This Referral Form		
Current Support Plan		