VAKAOLA
Pacific Community Health Inc

P.O.Box 56036,
Tawa, Wellington 5249, New Zealand.
Ph: (64 4) 232-7759 **Fax: (64 4) 232-7783**

CLIENT REFERRAL FORM

Clients Name: ______________________________

Address: ______________________________

Date of Birth: ______________ Male / Female ______________

Telephone Home: __________ Work :__________ Mobile: __________

Marital Status:______________ Ethnic Origin: ______________

Religion: ______________

Next of Kin / Significant Others: ______________________________

Address: ______________________________

Phone No: Work ______________ Home ______________

Referred By: ______________ Phone No. ______________

Designation: ______________________________

Agency / Organisation ______________________________

Hosp No: ______________ Legal Status: ______________

General Practitioner: ______________ Phone: __________

Psychiatrist: ______________ Phone: __________

Diagnosis: ______________________________

Benefit Type: ______________________________

Level of Care: ______________________________

Living Situation / Accommodation: ______________________________

____

Notice of Confidential Information
The information contained in this referral is confidential information intended for the individuality or entity named above. If you are not the intended recipient you are hereby notified that any use, review dissemination, distribution or copying of this document is strictly prohibited. If you have received this document error, please notify us by telephone and destroy the original message.

Any history of Drug / Alcohol Abuse: ______________________________

Reason for Referral ______________________________

____

____

____

Brief Mental Health (Psychiatric) History

____

____

____

____

Physical History

____

____

____

____

Social History

____

____

____

____

Clients Signature ______________________ Date: ______________

Referees' Signature: ______________________ Date: ______________

PACIFIC COMMUNITY HEALTH INC Mental Health Service is a service provider for clients from Pacific nations, their families and the community: (Please tick)

1. Cultural Assessment ☐
2. Home Based Rehabilitation & Support Services ☐
3. Day Activity Services ☐
4. Family Education & Support Services ☐

Notice of Confidential Information

The information contained in this referral is confidential information intended for the individuality or entity named above. If you are not the intended recipient you are hereby notified that any use, review dissemination, distribution or copying of this document is strictly prohibited. If you have received this document error, please notify us by telephone and destroy the original message.