Doctor/Health Professional Referrals

Please provide the following details to submit a referral to our database.

FREE Mental Wellbeing groups with referral
Courses are exclusively for clients with **mild to moderate** health issues
Clients must be 18+ and reside within the **WDHB catchment** area

Referral Date

dd-MMM-yyyy

REFERRER

Referring Practice *

Referring Doctor (or Health Professional) *

Referrer Phone *

Referrer Email *

CLIENT

Name *

First

Last

Address *

Street Address

Address Line 2

Suburb

Postal Code

Client Phone *

Client D.O.B (must be over 18) *

dd-MMM-yyyy

Client Email

Reasons for Referral

- [ ] Anxiety
- [ ] Stress
- [ ] Depression
- [ ] Confidence/Self-Esteem
- [ ] Anger
- [ ] Deeply distressed(Grief/Loss)
- [ ] Other - Please expand below

Other

Mild to Moderate Mental Health issues - Free Groups with Doctor's Referral

Please comment on:

1. **ANY FORMAL DIAGNOSES**
2. **HISTORIC concerns (**last 6 months) - suicidal/self-harm/psychosis/violence
3. **CURRENT** Mental Health status (suitability for group**)**
4. **PROTECTIVE FACTORS** Current Supports/Strengths

Other Relevant Information

IMPORTANT: Referrals cannot be processed without the information underlined below

Client has given their consent for this referral *

- [ ] *

For further information phone: 09 441 8989, or email us at learning@heartsandminds.org.nz

RETURN COMPLETED FORM TO:
learning@heartsandminds.org.nz or FAX: 09 441 8988

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