

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 or NGO) *

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 Deeply

Anger

distressed(Grief/Loss)

Other - Please expand below

Other

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

Please comment on:

ANY FORMAL DIAGNOSES

HISTORIC concerns (last 12 months) - suicidal/self-harm/psychosis/
violence **CURRENT** Mental Health status (suitability for group)

PROTECTIVE FACTORS Current Supports/Strengths

Any formal diagnosis *

**Historic and current
concerns (last 12 months) ***

Suicidal ideation /suicidal attempts / self-harm / psychosis / violence

**Current Mental Health
Status ***

Suitability for in-person and online groups

**Protective Factors Current
Support/Strengths ***

Other Relevant Information

**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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