Doctor/Health Professional Referrals

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

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/Provider *

Referring Doctor /Health Professional/NGO) *

Referrer Phone *

Referrer Email *

CLIENT DETAILS

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

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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 *

Has this Individual had any risk events in the past 12 months e.g: suicidal/self-harm/ psychosis/violence - Please advise *

Would you consider this individual to be safe in attending in person or online groups and courses? *

☐ **Yes** ☐ **No**

Current Mental Health Status - Would you consider this individual to be stable? *

☐ **Yes** ☐ **No**

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Protective Factors Current Support/Strengths *

Client has given their consent for this referral * ☐

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