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

29-Sep-2022

dd-MMM-yyyy
e.g. 01-Jan-2000

REFERRER DETAILS

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
e.g. 01-Jan-2000

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:**

Any formal diagnoses *

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

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

Submit