stepping stone trust
Te Roopu o te Taumata Kohatu
COMMUNITY MENTAL HEALTH RECOVERY SERVICES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

MINDSIGHT

MindWise Programme - Referral Form

12 Week Educational Group on Emotional Self-Management

Referral Date:	

Client Details:			
Last Name:		First Names:	
Date of Birth:		NHI:	
Gender:	☐ Male ☐ Female	Ethnicity:	
Street address:			
Suburb:		Area Code:	
Phone:		Mobile:	
Email:			

Next of Kin Details:			
Full Name:		Relationship to client:	
Phone:		Mobile:	
Email:			

Referrer's Details:			
Full Name:		Organisation:	
Phone:		Mobile:	
Email:			

GP Details:			
GP Name:		GP Practice:	
Phone:		Address:	

Please state below - current Mental Health Status / Diagnosis (if any):
Please state below - the objective of referring to the Mindwise Programme: