**Unaunahi Referral Form**

**(Youth Options Group)**

Please complete this form and email to: [youthreferrals@stepstone.org.nz](mailto:youthreferrals@stepstone.org.nz)

For respite referrals, please make contact directly with the Respite/Residential service to discuss a booking (03 332 6417/337 4997 or 027 489 5374).

PLEASE COMPLETE ALL SECTIONS

**You must attach with this referral copies of:**

* **Current Core Risks; and**
* **Latest Transition Plan** (both from Core Documents)
* **Current/most relevant Psychiatric Assessment**
* **Cultural Assessment**
* **Behavioural form (MST referrals)**

**Interventions being proposed:**

* Kaupapa Māori
* Tiakina (Developing & maintaining relationships)
* Community Support Worker
* Youth Mobile Service (Brief & intensive)
* Youth Respite –Targeted/Scheduled
* Youth Respite – Acute/Crisis Prevention
* Youth Residential
* Other (please specify…e.g. AOD)
* MST –please attach required MST forms

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| --- | --- |
| **Referrer Name**: | **Referral Date**: |
| **Phone**: | **Email**: |
| **Agency Name**: | |
| **Agency Address**: | |

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| --- | --- | --- | --- |
| **Client Name**: | | | |
| **Address**: | | | |
| **Contact Phone**: | | **D.O.B**.: | |
| **NHI**#: | **Ethnicity**: | | **Gender**: |
| **Does client have children? [ YES/NO ]** | **Diagnosis**: | | **Mental Health Act status**: |
| **Next of Kin/Principal Caregiver**: | | | |
| **Address**: | | **Phone**: | |

|  |  |
| --- | --- |
| **Case Manager Name** (if different from referrer): | |
| **Phone**: | **Email**: |
| **Agency Name**: | |
| **Agency Address**: | |

**Other Professionals Involved**

|  |  |
| --- | --- |
| **GP Name**: | **Email**: |
| **Phone**: | **Practice Name**: |
| **Practice Address**: | |
|  | |
| **Name**: | **Role:** |
| **Phone**: | **Email**: |

**Interventions already tried**:

**Current daily activities** (Education/Work)

**Rate client’s motivation (1-10) for engaging with support options:**

*Not motivated* 1 2 3 4 5 6 7 8 9 10 *Motivated*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Tiakina (Developing and maintain relationships) programme – Please circle days of attendance:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** | | **AM** | **AM** | **AM** | **AM** | **AM** | **11-7pm** | **11-7pm** | | **PM** | **PM** | **PM** | **PM** | **PM** | |

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| **Client Consent Obtained:** **YES:  NO:  (Please provide explanation)**  **All Required Documents (refer cover page) Attached:** **YES:  NO:  (Please provide explanation)**  **Referrer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |