Phone: 09 836 2329 / 0800 562 023
OPTION 1 – COUNSELLING and MENTORING
Address: 49 Lincoln Road, Henderson
414 Glenfield Road, Glenfield

For Counselling/Mentoring/Groups
Email: youthhub@healthwest.co.nz

YOUTH MENTAL HEALTH SERVICES: Please Tick your preferred option	◯ **COUNSELLING**
	◯ **MENTORING**
	◯ **YOUNG DADS PROGRAMME**
	◯ **GROUP**

RANGATAHI DETAILS:			**MAIN CONTACT:**
			Parent ☐ Guardian ☐ Caregiver ☐ Other ☐
Name:			**Name:**
Preferred Name:			**Relationship to Rangatahi:**
NHI:	**DOB:**	**Age:**	**Phone:**
Address:			**Email:**
Phone:			
Email:			
			ALTERNATIVE CONTACT:
Ethnicity:			**Parent ☐ Guardian ☐ Caregiver ☐ Other ☐**
Gender - Please specify:			**Name:**
Iwi			**Relationship to Rangatahi:**
GP:			**Phone:**
School:	**Year:**		**Email:**

Has the Rangatahi agreed to the referral? **Yes ☐** **No ☐**

Important Note: *Referrals are triaged with a representative from Marinoto Child and Adolescent Mental Health Services to determine the most appropriate pathway. If your referral is accepted contracted providers will also receive the referral form. Please ensure this is explained to the Rangatahi prior to consenting to the referral.*

Is the Rangatahi aware of the content of this referral? **Yes ☐** **No ☐**
If not, this is required prior to sending the referral to us.

Are the parents/legal guardian consenting to this referral? (Required if a Rangatahi is under 16 years)
Yes ☐ **No ☐**

If you also access the following Te Puna Manawa services do you give consent for your Mental Health records to be shared with them?

1. **School Based Health Services** *(Health Clinics in schools supported by Nurses and Doctors allowing students to access healthcare whilst at school)* **Yes ☐** **No ☐** **Not Applicable ☐**
2. **Youth Health Clinic** *(A free health service for rangatahi aged 12-24 years)* **Yes ☐** **No ☐** **Not Applicable ☐**

Do you consent to information about you being shared with the referrer? **Yes ☐** **No ☐**

Is it okay to send correspondence to the rangatahi electronically?	**Yes** ☐	**No** ☐

REFERRER DETAILS:	
Name:	**Organisation Details:**
Phone:	
Email:	
Date of Referral:	
Relationship to Rangatahi:	

Reason for your mentoring referral (Tick all relevant boxes)

☐ Life Skills
☐ Work readiness
☐ Emotional regulation
☐ Goal setting
☐ Social isolation
☐ Confidence/Self-esteem building
☐ Relationship building (Parents/teachers/partner)
☐ Career support
☐ Family stressors
☐ Other (Please specify)
_____

Reason for your counselling referral (Tick all relevant boxes)

☐ Anxiety
☐ Grief / Loss
☐ Anger
☐ Personal / Relationships
☐ Low Mood / Depression
☐ Alcohol/Drugs/Vaping
☐ Poor School Attendance
☐ Sleep disturbance
☐ Eating Issues
☐ Behaviour Issues
☐ Trauma
☐ Family Stressors
☐ Loss of Motivation
☐ Emotional Dysregulation
☐ Other_____

Any Safety Concerns? Please elaborate if present

Please indicate if any of the following are currently present or have been in the past:		**Please elaborate:**
Suicidal Ideation	☐	
Suicidal intent and/or plan	☐	
Suicide Attempt	☐	
Deliberate Self-Harm	☐	
Not Asked	☐	

Any Care and Protection Concerns?		**Please elaborate if YES**
Yes	☐	
No	☐	
Not Known	☐	

Presenting Concerns:
(*Please include current concerns, duration and frequency of symptoms. Impact on functioning e.g. impact on school such as grades, attendance, peer relationships. Changes in sleep, self-care, eating)*

Family (who lives with you):
(*Please include any shared care arrangements, custody arrangements, any recent changes or significant events e.g. bereavement. Any known mental health history)*

Current Medications:

Education/Work?

Referrers hopes/expectations:

Current Agencies/Workers Involved:

Is there anything else you would like us to know?

Once this form has been completed, please send to:
Youth Mental Health– youthhub@healthwest.co.nz
Please attach any other relevant information you feel may be helpful.