

**REFERRAL FORM – TE WHARE WAIMAIRIIRI**

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| **CLIENT INFORMATION** |  | | |
| **FIRST NAME:** |  | | |
| **LAST NAME:** |  | | |
| **ANY OTHER NAMES KNOWN BY:** |  | | |
| **DATE OF BIRTH:** |  | **NHI:** |  |
| **NHI:** |  | | |
| **GENDER:** |  | | |
| **ETHNICITY:** | **IWI (IF APPLICABLE):** | | |
| **ADDRESS:** |  | | |
| **PHONE/MOBILE:** |  | | |
| **EMAIL:** |  | | |
| **PRN Number:** |  | | |

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| **REFERRER INFORMATION** |  |
| **DATE:** |  |
| **NAME OF REFERRER:** |  |
| **ORGANISATION:** |  |
| **PHONE/MOBILE:** |  |
| **EMAIL:** |  |
| **CLIENT HAS CONSENTED TO BEING CONTACTED BY TE WHARE WAIMAIRIIRI** | **YES / NO** |
| **ONGOING SUPPORT WILL BE PROVIDED BY REFERRAL WHILE CLIENT IS AT TE WHARE WAIMAIRIIRI** | **YES / NO** |

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| **REASON FOR REFERRAL:** |

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| **CLIENT MUST HAVE SUCCESSFULLY COMPLETED AN INTENSIVE RESIDENTIAL ALCOHOL AND DRUG TREATMENT PROGRAMME:**  **NAME OF PROGRAMME:**  **DATE OF ADMISSION:**  **DATE OF COMPLETION:** |

**CURRENT SCRIPTED MEDICATIONS:**

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| **MEDICATION** |
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| **MENTAL HEALTH CONCERNS:** |
| **PHYSICAL HEALTH CONCERNS:** |
| **NAME OF GP:**  **ADDRESS:**  **EMAIL:**  **PHONE:** |

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| **OFFENDING HISTORY: PLEASE INDICATE IF CLIENT HAS ANY:**  **Probation Officer:**  **Conditions:**  **SEXUAL TYPE OFFENDING: YES / NO**  **VIOLENT TYPE OFFENDING: YES / NO**  **ARSON TYPE OFFENDING: YES / NO**  **Protection order/non association orders YES / NO**  **IF YES, PLEASE GIVE DETAILED OUTLINE OF OFFENDING (DATES, CONTEXT, AND WHETHER ANY TREATMENT HAS BEEN UNDERTAKEN IN RELATION TO THIS OFFENDING).** |

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| **FEE PER WEEK: $225**    **Fee per week:  $225.00 includes $100.00 per week refundable upon leaving the property (will be paid within 7 days of exit). Smoke detectors connected to the Fire Service are installed in all rooms. You may be asked to pay a call-out fee for alarms which go in your room if, for example, you were to tamper with the smoke alarm or attempt to smoke in your room.**    **Direct Credit to:**  **Bank:  ANZ**  **Account: 01-0777-00095803-000**  **Account Name:  Odyssey House**  **Branch:  Riccarton Branch, 97 Riccarton Road, Christchurch** |

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| **Please ensure that copies of the following are attached with this referral form** | |
| **Updated comprehensive AOD assessment** |  |
| **Photo ID – attached** |  |
| **Bank account details** |  |
| **Housing plan** |  |
| **Employment/training plan (include CV or other documents)** |  |
| **Copy of consent form** |  |
| **Mental health records** |  |
| **Copy of offending history** |  |
| **Treatment plan** |  |
| **Discharge summary (if applicable)** |  |

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| **EMPLOYMENT/TRAINING PLAN:**  **PLEASE OUTLINE WORK/STUDY PLAN:**   * **Is client currently in employment/study?** * **If yes, what is current role? Are they wanting to remain in role? What support do they need to do this?** * **What are their long-term career goals?** * **If not when are they due to start employment/study?** * **What support will they need to do this? (i.e., do they have appropriate work clothing?)** * **Would they be open to volunteering roles? If so, in which areas?** |

**EMAIL COMPLETED FORM AND ATTACHMENTS TO:** [**tewhare@odysseychch.org.nz**](mailto:tewhare@odysseychch.org.nz)