

**REFERRAL FORM – HAPORI ORA**

**Referral must include an brief AOD assessment and client consent form. Email to haporiora@odysseychch.org.nz**

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| **CLIENT INFORMATION** |  |
| **FIRST NAME:** |  |
| **LAST NAME:** |  |
| **ANY OTHER NAMES KNOWN BY:** |  |
| **DATE OF BIRTH:** |  |
| **NHI:** |  |
| **GENDER:** |  |
| **ADDRESS:** |  |
| **PHONE/MOBILE:** |  |
| **EMAIL:** |  |

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| **REFERRER INFORMATION** |  |
| **NAME OF REFERRER:** |  |
| **ORGANISATION:** |  |
| **PHONE/MOBILE:** |  |
| **EMAIL:** |  |

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| **REASON FOR REFERRAL:** |
| **MENTAL HEALTH CONCERNS:** |
| **ANY OTHER IDENTIFIED RISKS:** |