Youth Primary Mental Health Referral Form
Primary Mental Health Care Service

Fax to 09 438 3210 or Post to PO Box 1878 Whangarei

Date: …… Referrer Name: …… Contact Phone Number: ……

Client Name:				**D.O.B:**
Phone:	**Daytime:**	**Cell:**		**Night time:**
NHI:		**Ethnicity:**		**Gender: M / F**
Address:				
Next of Kin OR Emergency contact:	**Name:**	**Phone:**		
Parental awareness/consent given: (if patient under 17)	☐ Yes	☐No		
Patient GP:				
Current Medication(s):				
Presenting Problems:	☐Anxiety	☐ Sexual Abuse	☐ Other Abuse (Specify)	
	☐Depression	☐ Smoking	☐ Gambling	
	☐Anger	☐Illicit Drugs	☐ Alcohol problem related	
	☐ Exercise	☐ Other (Specify)	☐ Sleep	
Reason for Referral & Relevant history:				
Red Flags:	☐Psychotic Symptoms	☐Severe Self Neglect		
	☐Risk of harm to self/others	☐Suspected New-Onset Bipolar Disorder		
Assessment Score::	PHQ9 Score:	Kessler 10:	SDQ:	