



LifeLinks

Nga Oranga Mekameka
A Division of Compensation Advisory Services Ltd

Psychiatric and/or Alcohol and Drug NASC (0-64) Referral Form
Mate Hinengaro me Waipiro/Tarukino NASC (kore ki ono tekau ma wha) tuku tonu puka.

Date of Referral: _____ DOB: _____

Name: _____

Gender: Male Female NHI: _____

Address: _____

Phone: _____ Ethnicity: _____

N.B.
HAS THE ABOVE NAMED PERSON AND/OR CAREGIVER BEEN FULLY INFORMED OF THIS REFERRAL AND GIVEN CONSENT FOR THIS TO OCCUR? YES NO

ARE THEY AWARE A SUPPORT PERSON CAN BE PRESENT? YES NO

Key Contact Person / Family contact: _____

Contact details: _____

Diagnosing Consultant: _____

Doctor/GP: _____

Specialist Mental Health Service Team: _____

Diagnosis (Axis 1):
(Please indicate Primary if more than one) _____

Reason for Referral (to assist triage): _____

Risk / Safety Issues: YES NO

If yes, please indicate: _____

Legal Status: _____

Cultural/ Spiritual Issues (Interpreter Required): YES NO

If Yes, please indicate: _____

Specialist information / Discharge Summary attached: YES NO

Had previous Needs Assessment? YES NO

If yes – name organisation: _____

Referrer's Name: _____

Organisation: _____

Relationship to client (i.e. Case Manager/Nurse): _____

Email/Fax _____ Phone: _____