**Ember Akiaki Ora & Whiti Ora Referral Form**(Previously Ember Community Participation Service & Personal Focus)

We are required by our funders to gather the following information for statistical purposes & to confirm eligibility for services. It will also enable us to contact you & any people who will support you during your time with us. Missing information & documentation will slow down the referral process & your ability to attend the service.

For more information or to return your completed form & supporting documents please use one of the following**: Phone**: 8155113 **Email**: pf.admin@ember.org.nz **Address:** 51 Huia Road, Otahuhu, Auckland 1062
**Post**: PO Box 22424, Otahuhu, 1640

**Personal Details** (We will contact you or your referrer to gather any missing information before you attend)

|  |
| --- |
| Name:  |
| Date of birth:  | Contact phone:  |
| Address:  |
| Gender: [ ] Male [ ]  Female [ ]  Gender Diverse | Ethnicity:  |
| NHI #:  | WINZ#:  |
| Email address:  |
| What is your lived experience of mental illness/mental health diagnosis?  |
| Residency/Citizenship status? [ ]  NZ Citizen [ ]  NZ Permanent Resident [ ]  Other (please specify) |

**This referral is for**

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| --- |
| [ ]  Akiaki Ora - Individual support for pre-employment, further education and/or community engagement (16-65yrs) |
| [ ]  Whiti Ora - Group programmes (16yrs+) (please specify group/s)  |

**I can provide one of these forms** (Please send with your referral)

|  |  |  |
| --- | --- | --- |
| [ ]  Care plan  | [ ]  Wellness Recovery Action Plan WRAP) | [ ]  Early warning signs |
| [ ]  Risk assessment/management plan | [ ]  Similar document  | [ ]  I don’t have any of these |

**Support person/Service details** (Please provide at least one e.g. GP, clinical support, family/whanau)

|  |  |
| --- | --- |
| [ ] I am referring myself Referred by: name, phone & email details  |  |
| Key worker (or GP if you’re not with a Community Mental Health Centre) Name & contact details): |  |
| Family/Whanau/Significant other/ Emergency contact name & contact details: |  |

**Any additional information**

Do you have any medical conditions we should be aware of? [ ]  Yes[ ]  No If yes, please specify and how it affects you. Is there anything else you want us to know?

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**Declaration:** I give permission for Ember to approach my clinical provider / general practitioner / support worker for further information if necessary. This information will be kept secure along with all other personal records, as required by the Health Information Privacy Code (1993). **Signature of referred person:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
(Please do not sign on behalf of referred person)