**Logo, company name

Description automatically generatedEmber 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](mailto: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**

|  |
| --- |
| 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?

|  |
| --- |
|  |

**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)