Personal Focus Referral Form (PF-004)

Personal Focus is available to persons with lived experience of Mental Illness & aged 16yrs and over*. We are required by our funders to gather the following information for statistical purposes & to confirm eligibility to attend Personal Focus.
Missing information & documentation will slow down the referral process & your ability to attend the service.

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

Personal Details: (please complete all information)	
Name:	
Date of birth:	Contact phone:
Address:	
Gender: ☐ Male ☐ Female ☐ Other	Ethnicity:
NHI #:	WINZ#:
Email address:	
What is your mental health diagnosis?	
What is your residency/citizenship status? ☐ NZ Citizen ☐ NZ Permanent Resident ☐ Other (please specify)	

I would like to register for?

☐ Community Participation - Individual support for pre-employment, further education and/or community participation (*16-65yrs)

☐ Group programmes (please specify if known)

I have attached one of the following:

☐ Care plan ☐ Wellness Recovery Action Plan (WRAP) ☐ Early warning signs ☐ Risk assessment management plan

☐ I don't have any of these

Support person/Service details:	
Referred by (e.g. name of CSW, GP):	
Phone and email for above:	
Primary Service Provider name (e.g. CSW, CMHC, GP):	
Phone and email for above:	
Community Mental Health Centre (CMHC):	
Keyworker name & contact details:	
Family/Whanau/Significant other name & contact details:	

Additional information:

Further information we should be aware of:
Do you have any medical conditions we should be aware of? ☐ Yes ☐ No If yes, please specify and how it affects you

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