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**Personal Focus - Referral Form (PF-004)**

**Ember, Personal Focus Service**

**Physical address**: 51 Huia Road, Otahuhu 1062 **Mailing address**: PO Box 22424, Otahuhu, 1640
**Phone**: 8155113 **Fax**: 8496864 **Email**: PF.admin@ember.org.nz

**Section 1**

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.**

**Personal Details: (Please complete all parts)**

**Name:** **D.O.B:**

**Address:** **Contact Phone:**

 **Gender:** [ ]  Male [ ]  Female

 **Ethnicity:**

**WINZ No:**  **NHI No:**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your Mental Health Diagnosis?
Tick the square which best describes your citizenship or residence status**

[ ] New Zealand Citizen (NZL)

[ ] New Zealand Permanent Resident (NZP)

[ ] Other (Please specify):

**Tick the square which best describes your Smoking Status**

[ ] Never Smoked

[ ] Ex Smoker (have not smoked within the last 28 days)

[ ] Current Smoker

[ ] I would like support from Personal Focus to quit

**Reason for referral (Please tick the appropriate box/es)**

[ ] Individual support towards employment, study or involvement in your community

|  |
| --- |
| **Please attach one of the following:** |
| [ ] Care Plan | [ ] Risk Management Plan |
| [ ] Wellness Recovery Action Plan (WRAP) | [ ] Risk Assessment |
| [ ] Early Warning Signs | [ ] I don’t have access to any of these |

[ ] Personal Focus groups. If known, what groups? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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).

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**Signature of Referred Person Date**

**Please complete second page**

**Section 2**

The following information is required to enable us to provide a safe & efficient service for programme participants.

**Support Person/Service Details:**

**Primary Service Provider:**

**Contact Person:**

**Address:**

**Phone:**

**Email:**

**CMHC:**

**Family/Whanau contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Significant other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Additional Information:**

***Do you have further significant information we should be aware of?* E.g. Medical conditions such as Diabetes, Epilepsy etc.**

**[ ]  Yes [ ]  No (If yes please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***How do these affect you?***

**Is there anything else you feel is important for us to know**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Office Use Only**

Contact details complete **[ ]  Yes [ ]  No**

NHI # included **[ ]  Yes [ ]  No**

WINZ # included **[ ]  Yes [ ]  No**

Meets Eligibility Criteria **[ ]  Yes [ ]  No**

Meets Citizenship Criteria **[ ]  Yes [ ]  No**

Registered on Life Data **[ ]  Yes [ ]  No**

Smoking information recorded in Life Data **[ ]  Yes [ ]  No**

Wellness Management plan included **[ ]  Yes [ ]  No**

WRAP plan included **[ ]  Yes [ ]  No**

Medical Information added to Life Data Alert **[ ]  Yes [ ]  No [ ]  Not Required**

Referred by WINZ (if yes, please record branch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) **[ ]  Yes [ ]  No**

Initial contact date (if before registration) ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Follow up Action required (& by whom): \_\_\_\_\_\_

Signed off by (Senior Programme Coordinator or Team Leader)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date signed off:

**Personal Focus Referral Pathway**

**Time Frame** – In most cases the referral process takes no more than seven working days from when the referral is received.

\****The Service Induction*** is a meeting that will help plan your pathway through the Personal Focus programme by identifying your dreams and aspirations using the Strengths Model as well as familiarising you with the service.