Te Puna Ora Wellness Addiction Counselling Service

Alcohol & Other Drugs (AOD) – REFERRAL FORM

Referring Agency: Date:

Referrer Name: Tel No:

Email:

Referrer discussed referral with the client: YES/NO

Client Name Date:

DOB NHI:

Address Phone Number (H)
(Cell)
(Work)

Gender Ethnicity GP

Are you working/studying or neither?

Reason for referral: AOD drop-in clinic

Sect 65/Comp AOD Rep

Current substance use involvement Justice Department

Identified mental health issues Other professionals involved

Risk

Harm to self	Past	Current
Harm to others	Past	Current
Harm from others	Past	Current

Further action required (Office only)

No further action _____ For allocation: Yes/No

Comments:

www.tepunaorawellness.co.nz
Mobile: 020 4087 3329
Email: tpo.wellness@outlook.com
Taniwha Counselling Services Limited