Eastern Bay Primary Health Alliance
Healthy Whānau, Healthy Lives

Louvain Street
Whakatane 3120
Phone: 07 306 2300
Fax: 07 306 2399

Primary Health Counselling Service Referral

Client Name			Date of Birth		
Also known as		NHI (if known)		Date of referral	

Client Address					
Phone No			**Mobile**		
Email					
Gender	□ Male	□ Female	**NZ Citizen / Resident**	□ Yes	□ No
Ethnicity	□ Māori	□ NZ European	□ Samoan	□ Tongan	□ Cook Islander	□ Niuean	□ Indian
	□ Asian	□ Other, please specify					
Carer details (if applicable)	**Full name**						
Address							
Contact details	**Home**		**Mobile**				
Email			**Emergency Contact**	□ Yes	□ No		
If no, please complete the following details for the Emergency Contact							
Full name							
Contact details	**Home**		**Mobile**				
Address							
Referred by	□ GP	□ Self	□ BOPDHB	□ School	**Assessment attached?**	□ Yes	□ No
	Other (Please state)						
Reason for Referral							
Any presenting problems							
Alcohol or Drugs, Gambling							
Medication (if applicable)							
School/Employment							
Legal status							

Eastern Bay Primary Health Alliance
Healthy Whānau, Healthy Lives

Louvain Street
Whakatane 3120
Phone: 07 306 2300
Fax: 07 306 2399

Other services involved (please list below)			
Risk (self-harm, suicidal thoughts, violence) □ **Low** □ **Medium** □ **High**			
Smoking Status: (✓) *Please use the 'mouse' in this section* Never smoked Ex-smoker *(has not smoked in the past 30 days)* Current smoker *(has smoked in the past 30 days)*	□ Yes □ No □ Yes □ No □ Yes □ No	Cessation Support for Smokers: (✓) Client would like cessation support:	□ Yes □ No
Client/Caregivers have agreed to this referral	□ Yes	□ No	

Referrer name		**Referring Service**	
Referrer email		**Phone details**	
E-Signature: ***Please use an e-signature or enter your full name here***			