Health New Zealand
Te Whatu Ora
Whanganui

| Patient Label | |
|---|---|
| **Surname:** | **NHI:** |
| **First Names:** | **Ward:** |
| **Address:** | **DOB:** |
| | **ACC No:** |
| **GP:** | |

Private Bag 3003, Whanganui, Phone: 06 348 1901, Email: icamhas@wdhb.org.nz

# Infant Child Adolescent Mental Health and Addiction Service referral

**SECTION ONE – Identifying Information:**

Infant/child/young person's name: _____

NHI: (if known) _____ D.O.B: _____ Age: _____

Gender: male female trans other *(circle one)* Ethnicity: _____

Address: _____ Phone number: _____

Email (for appointments/letters): _____

***(All appointments and letters will be sent via this email address)***

Parents name, address, email & phone number (if different from above):_____

_____

Current caregiver's name, address, email & phone number (if different from above): _____

_____

Name of GP: _____ GP Practice: _____

Name of Referrer: _____ *(Please print)*

Phone number: _____ Email: _____

Name of referring organisation (if applicable):_____

**CONSENT TO REFERRAL:**

Are the parents and/or caregivers aware of this referral? Yes [ ] No [ ]

If 16 or over, are you happy for parents and/or caregivers to receive letters? Yes [ ] No [ ]

Is the young person aware of this referral? Yes [ ] No [ ]

Has consent been obtained for this referral, including those from 16 years? Yes [ ] No [ ]
If no, please explain.

_____

_____



Catalogue No: 0335
Date form created: 19 February 2024
Next review Date: 19 February 2026

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**SECTION TWO – Reason(s) for Referral:** What is the mental health and/or alcohol or other drug issues/problems/risk factors? Please include: changes in sleep pattern, appetite, behaviour, mood, academic functioning and whether there is a risk to self or others, including self-harm.

_____

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**SECTION THREE - Health Status**
Current medication or medical issues:

_____

_____

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_____

**SECTION FOUR - Other Comments**
Any additional information relevant to this referral. Including; family history of mental health and/or alcohol and other drug issues, other agencies involved.

_____

_____

_____

_____

**Please email this referral form to** icamhas@wdhb.org.nz



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