Health New Zealand
Te Whatu Ora
Whanganui

SUPP

Patient Label

Surname:
First Names:
Address:

GP:
Consultant:

NHI:
Ward:
DOB:
ACC No:

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

SUPP – a place for 12-19 year olds to have straight up conversations around alcohol, drugs and mental wellbeing

Young person details:

Surname: _____ First Name: _____

NHI (if known): _____ Date of Birth: _____ Age: _____

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

Address: _____

Email: _____ Phone number: _____

Preferred method of contact: text email call (circle one)

School/Course: _____

Parent/Caregiver: *(If applicable)* _____ Phone: _____

Has the young person previously been seen for mental health and addiction issues? Yes [ ] No [ ]
If yes, when and where?

CONSENT TO REFERRAL:

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

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

Reason(s) for referral: _____

_____

_____

_____

_____

_____

Name, phone and email of referrer: _____

_____

Name of Referring Organisation (if applicable): _____

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

SUPP Service referral

Catalogue No: 0464
Date form created: 19 February 2024
Next review date: 19 February 2026