WHIRINAKI TRIAGE INFORMATION FORM
Phone: 09 265 4000 Fax: 09 265 4199

CLIENT DETAILS:

Surname: ______________________ **Parent/Caregiver:** ______________ **Ph:** ______________

First Name: ______________________ **Other Contact:** ______________ **Ph:** ______________

A.K.A.: ______________________ **GP:** ______________ **Ph:** ______________

DOB: ________ **Sex:** _____ **NHI:** ___________ **School:** ______________ **Ph:** ______________

Address: ____

____

Dog at home: Y / N **Transport: Y / N**

Ethnicity: ______________________ **Country of Birth:** ______________________

Language Spoken: ____________ **NZ Resident: Y/N** **Date of Entry into NZ (if known):** ___________

REASON FOR REFERRAL:

____

What is the specific mental health question that you wish our service to respond to?

____

Level of urgency ☐ **URGENT** ☐ **SEMI URGENT** ☐ **ROUTINE**

Duration of Concerns: ____

Do Parents/Caregivers/Patient know of referral? Y / N

REFERRAL SOURCE

School ☐ GP ☐ CYFS ☐ Starship ☐ Parents/caregivers ☐ Psych Liaison ☐

Other ☐ ____ (please specify)

Name: ______________________ Designation: ______________________

Contact Details: ____

OTHER AGENCIES ALREADY INVOLVED

CYFS ☐ GSE/RTLB ☐ SGC ☐ ACC ☐

Others ☐ ____ (please specify)