

# Referral Form

Please complete and email to: [admin@futures.nz](mailto:admin@futures.nz)

I wish to refer for the following services:

TYPE OF REFERRAL	<input type="checkbox"/> Individual Psychology Services (Assessment & Treatment)
	<input type="checkbox"/> Group Programme: _____ (DON'T REQUIRE CLIENT CONTACT or ADDRESS DETAILS)
	<input type="checkbox"/> FUTURES YOUTH LAB Services: _____

CLIENT NAME			DATE OF REFERRAL		
DOB		AGE		ETHNICITY	
				Gender	M <input type="checkbox"/> F <input type="checkbox"/>
DAY PHONE			MOBILE PHONE		
CLIENT ADDRESS			LEGAL GUARDIAN (if applicable)		
LEGAL GUARDIAN ADDRESS (if different)			LEGAL GUARDIAN PHONE (if applicable)		
REFERRING ORGANISATION			CONTACT PERSON		
CONTACT DETAILS			INDIVIDUAL HAS BEEN MADE AWARE & AGREED TO REFERRAL	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Only complete this section if referring for Individual Psychology Services:

REASON FOR REFERRAL	
ASSESSMENT/ TREATMENT GOALS	

DETAILS OF OTHER PROFESSIONALS INVOLVED (GP's, Counsellors, Psychiatrists, Substance Abuse, Mental Health etc.)		RELEVANT MEDICAL HISTORY	
SIGNIFICANT OTHERS INVOLVED			

## Thank-You for your referral

If you would like to discuss any aspects of this referral further, please do not hesitate to contact us.  
These details must not be released to anyone including the client and/or third parties without the expressed permission of the author.

Waikato & Bay of Plenty

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