Canterbury District Health Board
Te Poari Hauora ō Waitaha

CDHB Child & Adolescent Mental Health Referral Form

Please send completed referral form to:
Email: caflink@cdhb.health.nz
Fax: (03) 337 7822
Address: Private Bag 800, Christchurch 8140

If you have any issues completing this form please contact CAFLink for advice: 0800 218 219

All of the following criteria must be met

- From the age of 0 - 18 (if patient 18 years and still at school contact CAF to discuss appropriateness)
- Resides in the Canterbury District Health Board catchment area
- Needs of the child cannot be met by a relevant community agency **AND**

Known or suspected mental illness and significant signs and symptoms **AND**

Moderate to severe impairment in **TWO** or more of the following areas:

- Serious suicidal thinking or imminent risk to self and others
- Education
- Family/Whanau
- Peer/social group
- Identity ie cultural, gender
- Ability to provide developmentally appropriate self-care
- Contextual factors relating to:
  A parent with a significant mental illness and/or addiction, Multi-service involvement

Demographic details

Name of Child or Young Person:			NHI:
Age:	Gender:	DOB:	Ethnicity:
Address			
Phone- Home	Cell:	Work:	
Parents/Guardians/Whanau:			
Address *(if different from above)*			
Phone- Home	Cell:	Work:	
Caregiver *(if different from above)*			
Address *(if different from above)*			
Phone - Home	Cell:	Work:	
School and Year:			

Does the client know about and agree to this referral?	YES	NO
(if under 16 yrs do the parents/caregivers know and agree?)	YES	NO
Are there any specific cultural, language or disability needs?	YES	NO

If Oranga Tamarki is involved please note social worker name:

Referrer name and contact details:

Request

Reason for referral (please indicate):

	Assessment (include risk)		Phone advice
	Review of medication or renewal of special authority		Written advice
	Transfer of care		Other:

What is the primary concern for referral (please indicate)?

Risk to self/others (imminent and/or increasing)		Hallucinations, confused thinking/behaviour (psychosis)	
Phobias or worries (anxiety)		Low or elated mood (mood disorders)	
Attention and concentration difficulties (ADHD)		Obsessions/compulsions (PTSD/anxiety)	
Eating difficulties (eating disorders)		Alcohol or other drug misuse (AOD addiction disorders)	
Behaviour leading to mental health concerns (e.g. elation or withdrawal)		Social difficulties (Autism spectrum disorder if aged over 14)	

Other (please clarify):

Has the patient been referred elsewhere, if so, where?

Clinical concerns – describe presentation (MUST COMPLETE)

Main signs/symptoms, Assessment of severity, degree of patient distress, functional impairment, risk to self/others including suicidality, any previous contact with mental health or social services, other health concerns and education-based assessments, what support or interventions have been tried. Relevant investigations/ medications. Allergies/warnings

Goals – what are patients/families goals? What do they want help with from the service?

Relevant physical observations (required for referrals concerning an eating disorder)

Date:	Height:	Pulse:
Blood pressure (lying and standing):	Current weight: Weight loss in last month:	B.M.I:

Please be aware if this form is not fully completed it may delay access to the service
Please send as much information as possible – including copies of any previous assessments/reports