St John of God Hauora Trust

Eating Awareness Team Referral Form

IT IS NECESSARY FOR THE PERSON TO KNOW THIS REFERRAL IS BEING MADE

Program ☐ Individual counselling ☐ Assessment ☐ Education nights

Referral Source ☐ For myself ☐ Family member ☐ Agency referring

Client Information

First name:		Surname:	
Daytime phone:		Mobile:	
Gender:		Date of birth:	
Occupation or school:		Best time to contact:	
Postal address:		Living situation:	

Ethnic Identity ☐ Maori ☐ NZ European ☐ Pacific ☐ Other

Iwi/other

Next of Kin / Alternative Contact

Name:		Phone:	
Address:		Relationship:	

Agency Referral

Name:		Role:	
Daytime phone:		Fax:	
Email:		NHI:	
Location:			

GP Details

Name:		Phone:	
Practice:		Fax:	

Reason for referral/Current difficulties (restricting, binging, purging, body image):

Relevant health information:

Any previous relevant mental health history (if known):

How did you hear about the Eating Awareness Team Waipuna?