Kari Centre Child and Youth Mental Health Service
Referral Information

Kari Centre
Phone: (09) 623 4646
Fax: (09) 623 4611
Address: Ground Floor
Building 13
Greenlane
Clinical Centre
Auckland

COMMUNITY CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

- The Kari Centre is the community based child and adolescent mental health service for children, adolescents and their families/whanau living in the central Auckland area. The areas we cover are Avondale to Panmure; Otahuhu to the Harbour Bridge.
- We are part of the Auckland District Health Board and our service is free of charge to New Zealand residents. We are based in the Greenlane Clinical Centre.
- We provide assessment and a range of treatments by multidisciplinary teams of mental health professionals. Treatment can involve individual therapy, family therapy, group therapy, case management and medication. We also provide consultation and liaison with other health providers and agencies including CYFS and education/schools. Psycho-education and cultural support are generally included in these services.
- Our teams include Social Workers, Psychiatrists, Psychologists, Occupational Therapists, Child Psychotherapists, Community Mental Health Nurses and Cultural Workers. We also have a visiting paediatrician.

WHO DO WE SEE?

- We are funded to provide assessment and intervention for infants, children and adolescents (0-18) with moderate to severe mental health problems and their families. Treatment can involve individual therapy, family therapy, group therapy, case management and medication.
- Acceptance criteria are based on symptoms suggesting a moderate to severe mental health issue, such as low mood, anxiety, unusual behaviour including hyperactivity, eating difficulties, impairment in functioning related to mental health, preoccupation with thinking about death, deliberate self-harm, marked withdrawal or isolation and impairment of reality testing.
- We are unable to accept referrals for clients whose main problems involve substance abuse, physical/sexual abuse, neglect, intellectual disabilities, brain injuries and elimination difficulties.

MAKING A REFERRAL

- The Kari Centre are happy to accept referrals from any professional involved in the young person's care, including church pastoral staff. We expect the referrer to have discussed the problem and the referral with the young person and their family/whanau. Kari Centre does not accept self-referrals. Over weekends and outside normal business hours, referrals requiring a crisis response should be directed to the Crisis Team on 0800 800 717.

- Attending the Kari Centre is usually voluntary, so please get the young person and family's permission before referring.
- When you refer to the Kari Centre your referral will be processed by the intake team. Depending on the referral information, families may be offered a brief assessment with our intake team to find out more about their concerns and to help decide whether the Kari Centre is the right service to assist or not. Alternatively, families may be allocated directly to one of our community teams for a comprehensive assessment.
- What to expect: Once the referral has been received, the Kari Centre may make contact with the referrer to discuss the case or gather more information. Referrers will always be informed of the outcome of a referral. Kari Centre will usually see a young person accepted for assessment within one month of referral. Urgent referrals will be given priority and seen as soon as required.
- **Please describe the young person's mental concerns in as much detail as possible, as this may help us decide if they need a screening appointment first or if they will be allocated directly to one of our community teams.**

IN YOUR REFERRALS PLEASE DESCRIBE:

- Symptoms of mental health, including description of mood, any anxieties/worries, sleep or appetite changes, thought disorders, hallucinations.
- How often the client is experiencing these symptoms and what time period they have been experiencing them for.
- Try to be very specific about behaviours observed, eg: as well as stating "suffers from panic attacks", note the specific physiological symptoms of panic attacks they experience (such as shortness of breath, racing heart, shakiness, dizziness or fear of losing control/dying).
- Any difficulties you think the family may have in attending appointments or engaging with our service (eg: transport issues, work or childcare commitments, cultural or language barriers)

The intake team is very happy to talk to you about your referral before you send it. We also have a referral form available and typed referrals are appreciated! Any questions, phone intake - 09 6234646.

KARI CENTRE COMMUNITY TEAM
REFERRAL FORM

Building 13 Greenlane Clinical Centre 214 Greenlane Rd Private Bag 92 189 Auckland 1142
Ph: 623 4646 Ext. 28621 or ask for Intake, Fax: 623 4612

 Date:

Client Name: _____ DOB ____/____/____ Age:_____ Female: ☐ Male: ☐

Address: _____

Phone: (Home): _____Client's Mobile : _____ Client's Email _____

Ethnicity: _____ NZ Citizenship/Residency: (✓) YES ☐; NO ☐

Language/Interpreter required? (For family or client)_____

Does the whanau/family know about and agree to this referral: (✓) YES ☐; NO ☐
I have met with the young person about this referral and have they agreed: (✓) YES ☐; NO ☐

Guardian/ Mother's Name: _____

Guardian/ Mother's Contact: Phone: (Home): _____ (Work): _____

Mobile:_____ Email:_____

Guardian/Father's Name:_____

Guardian/ Father's Contact: Phone: (Home): _____ (Work): _____

Mobile:_____ Email:_____

Current Adult Caregiver(s): _____

Caregiver's Phone and Email (if different from above):_____

Ethnicity of parents/caregiver(s):_____

Family Doctor: _____ Phone_____

School: _____ Contact Name: _____

Phone: _____ Fax:_____

Referrer: _____ Relationship to client: _____

Organisation or Designation: _____

Address: _____

Phone: Mobile: Email:

CYFS Involvement YES ☐ Social worker name?_____
NO ☐ CYFS Status

OTHER AGENCIES INVOLVED: (Past/Present)

FOR CURRENT CARE & PROTECTION/SAFETY ISSUES ENSURE THE APPROPRIATE AGENCIES ARE NOTIFIED i.e. CYFS, POLICE

Do you think the family will have any difficulties attending appointments or engaging with our service (eg: transport issues, work or childcare commitments, cultural or language barriers)? If so, is there anything that can be done to support them?

Client Name (if faxing)_____

Have you consulted with Kari Centre about this client in the last 6 months? YES: ☐ NO: ☐

HOW LONG HAVE THERE BEEN MENTAL HEALTH CONCERNS FOR THIS YOUNG PERSON?

SAFETY ISSUES: (✓) YES: ☐ NO: ☐. If 'YES' please elaborate including when concerns last present:

Suicidal Thoughts/Acts: _____

Self harm Behaviour: _____

A Danger to Others: _____

Abuse/neglect: _____

Are you comfortable with your safety plan YES: ☐

NO: ☐ CALL KARI CENTRE INTAKE ASAP TO DISCUSS

PLEASE DESCRIBE THE MENTAL HEALTH CONCERNS e.g. emotional, behavioural, social or school issues:

RELEVANT FAMILY ISSUES eg. Parental separation/divorce, death, conflict, mental heath issues, financial stress

OTHER CONCERNS eg. Significant trauma/stressors, previous psychiatric diagnosis, medical issues, medication, substance use/abuse

WHAT ASSISTANCE IS REQUESTED?

PLEASE ATTACH ANY FURTHER INFORMATION YOU FEEL IS RELEVANT

Marinoto North and West Child and Youth Mental Health Services
Referral Information

Please DO NOT email any referrals to Marinoto. Please fax to the number provided on the referral form or alternatively post to: Marinoto West, Private Bag 93115, Henderson, Auckland 0650

DATE:

MARINOTO WEST CHILD & ADOLESCENT MENTAL HEALTH SERVICES
REFERRAL FORM – PH: 822 8666

Child/Young Person's Details:

Name		D.O.B.	Gender
Address Phone: Mobile:			
NHI	GP	Ethnicity	Iwi
School			

Is the Child/Young Person aware of this referral? Y/N
Is the primary caregiver aware of the referral? Y/N

Referrer:

Name	Relationship to Child/Young person:
Work Address Phone: Mobile:	

Primary Caregiver Details:

Name	Relationship to Child/Young person:
Address Phone: Mobile:	

Family Structure: *(include who the child/young person live with and any other significant family relationships)*

/

Presenting Issues *(include risk behaviour and significant medical history)*

Current Agency Involvement:

Past Agency Involvement:

Please send to: Marinoto West
'Waimarino Building'
Level 1, 33 Paramount Drive, Henderson
P O Box 93 115, Henderson

Or fax to: 822 8672

MARINOTO NORTH CHILD & ADOLESCENT MENTAL HEALTH SERVICES REFERRAL FORM

Child/Young Person's Details:

Name		D.O.B.	Gender
Address Phone: Mobile:			
NHI	GP	Ethnicity	Iwi
School			

Is the Child/Young Person aware of this referral? Y/N
Is the primary care giver aware of the referral? Y/N

Referrer:

Name	Relationship to Child/Young person:
Work Address Phone: Mobile:	

Primary Care Giver Details:

Name	Relationship to Child/Young person:
Address Phone: Mobile:	

Family Structure: *(include who the child/young person live with and any other significant family relationships)*

Presenting Issues *(include risk behaviour and significant medical history)*

Risk Issues

Care & Protection Concerns

Referral Question *(What do they want from our service)*

Current Agency Involvement:

Past Agency Involvement:

Whirinaki Child, Family and Youth Mental Health
Referral Information

WHIRINAKI REFERRAL FORM

Phone: 09 265 4000 **Fax: 09 265 4199**

Date:_____

YOUNG PERSONS DETAILS:	PARENT/CAREGIVER DETAILS:
Surname:_____	Surname: _____
First Name/s _____	First Name: _____
DOB: _____ Gender: _____	Ph: (Hm) _____ (Mob) _____
NHI: _____	Email: _____
Ethnicity: _____	Dog at home: Y/N Transport: Y/N
Language Spoken: _____	Ethnicity: _____
Address: _____	Language Spoken: _____
_____	Address: _____
Mobile ph: _____	_____

Who is the client currently living with (plus contact details)? _____

GP: _____ Ph: _____

School: _____ Ph: _____

Country of Birth: _____ NZ Resident: Y / N Date of Entry into NZ: _____ (if known)

Concerns: _____

_____

_____

_____

_____

_____

Duration of Concerns: _____

Why are you referring to Whirinaki at this time? _____

_____

_____

_____

Is the child/young person at immediate risk? **Y** **N**

If Yes, what is the risk: _____

_____

_____

_____

Does the child/young person know of this referral and the information contained in it? Y N

Do the parents/caregivers know of this referral and the information contained in it? Y N

REFERRERS DETAILS:

Name: _____ **Agency/Organisation:** _____

Role: _____ **Contact Details:** _____

OTHER AGENCIES ALREADY INVOLVED AND CONTACT DETAILS

CYFS ☐ MoE/RTLB ☐ SGC ☐ Others ☐ _____(specify)

Contact details: _____

PLEASE ATTACH ANY ADDITIONAL REPORTS THAT MAY BE HELPFUL **(Form revised February 2011)**