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**Health Professional’s Referral Form**

Your Name:

Your Email and Phone:

Your Role:

Your Organisation:

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Client’s Name:

Client’s Phone and Email:

Client’s Date of Birth:

Client’s NHI (if known):

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Nature of the problem:

Referral Reason:

Please comment on known risk: Suicidality, alcohol and other drug use, eating disorders etc

Psychometric test scores and dates (BAI, BDI etc…)

Duration of current problem:

Will your client need funding to attend sessions: Y / N / Not sure

Has the person consented to this referral? Y / N / Not sure

Please attach any other relevant information.

Email your competed form to: [reception@anxiety.org.nz](mailto:reception@anxiety.org.nz)

**Support, Treatment and Education for Anxiety and Depression.**

**T:** 09 846 9776 **|** **W:** anxiety.org.nz **|** 24-hour Anxiety helpline: **0800 269 4389** 0800 ANXIETY

PO Box 41133, St Lukes, Auckland 1346. **|** 77 Morningside Drive, Mt Albert, Auckland 1025 **|** **F:** 09 849 2375

If you need urgent assistance outside of office hours, please call our free 24 hours - 7 days a week national anxiety line. Clinicians as well as highly skilled

volunteers have been trained in relaxation techniques and breathing exercises. 24-hour National Anxiety Line: 0800 ANXIETY (0800 269 4389).