

MUST ATTACH PATIENT LABEL HERE (for ADHB use only)

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

ARANGA TĒTĒKURA INTERPROFESSIONAL ADVISORY FORUM (IPAF) REFERRAL

Referrer name / Designation:

Referral Date:

(Lead Maternity Carer (LMC), GP, Health Social Work (HSW), Oranga Tamariki (CYF), Well Child Provider (WCP), Police, other, etc.)

Whaea / Woman:

Name:

Ethnicity:

EDD:

Lead Maternity Carer booking date:

Iwi (optional):

Hoa rangatira / Partner:

Name:

Ko wai ngā kaiawhi noho tahi kia koe / Support people that live with you:

Current LMC Kāhore/No Āe/Yes Name:

Health Worker Kāhore/No Āe/Yes Name:

Maternal Mental Health Keyworker Kāhore/No Āe/Yes Name:

Other service involvement Kāhore/No Āe/Yes Please specify:

Ngā āwangawanga – current concerns and reason for referral:

- | | | |
|--|---|--|
| <input type="checkbox"/> Parenting ability/life skills | <input type="checkbox"/> Criminality | <input type="checkbox"/> Suicidal ideation |
| <input type="checkbox"/> Poor engagement with maternity care | <input type="checkbox"/> Teenage parent/s | <input type="checkbox"/> Oranga Tamariki |
| <input type="checkbox"/> Transient lifestyle/homelessness | <input type="checkbox"/> Cognitive impairment | <input type="checkbox"/> Family violence |
| <input type="checkbox"/> Child protection concerns | <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Mental health |
| <input type="checkbox"/> Clinical or health concerns associated with pregnancy | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Attachment |
| <input type="checkbox"/> No antenatal care | | |
| <input type="checkbox"/> Other (specify): | | |

Situation (brief summary)

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Nga kaha to te wāhine nei – identified strengths and support:

I roto i tōku whakaaro - situation in my opinion is:

Urgent High Medium Low Consultation only

Kua whakae te wāhine ki enei kōrero – has this referral and patient's rights been discussed with the woman?

Āe/Yes Kāhore/No

Ka pēhea te tautoko i te wahine nei? – what are you hoping to achieve by making this referral to Aranga Tētēkura IPAF

e.g. support for woman, sharing information holding of risk, interprofessional advisory forum care planning etc.

Tokohia ngā tamariki ā wāhine nei? – are there other children? *If yes please give details (Names, DOB):*

Āe/Yes Kāhore/No

Na wai atu i tautoko te whānau nei? - professionals or agencies involved with this family?

If yes please give details: such as Maternal Mental Health, CADS Pregnancy Parental Service, Oranga Tamariki (CYF), SHINE. Women's Health Social Work, Well Child Provider

Additional Notes:

Waitohu / Nama waea – name, professional title, contact details of the referrer and signature:

Name:

Professional title:

Email:

Phone:

Signature:

PLEASE EMAIL: arangatetekura@adhb.govt.nz marked Aranga Tētēkura Coordinator (Confidential)
You should expect an email confirming receipt of referral.