Massey University
Psychology Clinic (PN)

Self-Referral Form (for Young People Under 16)
Massey University Psychology Clinic

Psychology Clinic PN319 Massey University Private Bag 11222 Palmerston North Phone (06) 350 5196
Email to: massey.clinic.pn@massey.ac.nz

Date of Referral	
Client Name	
Date of Birth	
Age and Gender	
Ethnicity	
Contact Address *(incl. Postcode)*	
Telephone Number(s)	
Parent/Guardian Name(s)	
Parent/Guardian Contact details	
Can we leave messages? Yes/No	
Email Address	
Referred by (Self/GP etc.)	
GP	

Reason for referral	
Is there a current diagnosis by a health professional?	Yes/No – If Yes please give details.
Are there any custody or access issues related to this child? N.B.Please see consent section at the end of this form.	Yes/No – If yes please specify. Who has custody of this child? Sole or shared? Who has guardianship of this child?
Are you likely to require report for any legal proceedings?	Yes/No – If yes please specify. Please note that we do not usually provide reports for any Court related or legal proceedings.

Are there any other services currently involved?	
Has this child seen a psychologist previously?	Yes/No - If yes please give brief information on when, for how long, what focused on & what outcome?
Brief outline of current treatment including any ongoing medication.	
Are there any current safety issues: e.g., suicidal – associated with low mood.	Yes/No If yes, please call the Mental Health Crisis Team – a 24 hour service on: 0800 653 357
Contact instructions	Please advise if there are any good/bad times of the day for us to call you, and if you would prefer email contact over phone contact.
Any other additional Information?	

What type of service do you need? (Please select any of the following)

☐ Formal Cognitive Assessment ☐ Assess the current situation and / or therapy

Will this be privately funded or funded by an organisation?

☐ Privately funded

☐ Funded by an organisation (Please specify) _____

When privately funded our therapy fees are on a sliding scale based on family income. Please indicate which income bracket you would be in.

☐ Up to $70,000

☐ Over $70,000

Because we are a training clinic, you may be seen by an Intern. An Intern is in their final year of clinical training and supervised by a Senior Psychologist. Please confirm you consent to this.

☐ Yes ☐ No (we may not be able to progress your application)

Please confirm that that this child is happy for this referral to be made.

☐ Yes ` ☐ No

Consent

Our clinic policy is that all legal guardians need to provide consent for any assessment or therapy of a young person under the age of 16. Guardianship is usually automatic for both parents, and can only be removed by Court order. Custody is different to guardianship and does not necessarily remove guardianship rights.

Please provide the names, contact details, and signed consent of ALL legal guardians

1. Name _____

   Relationship to Child _____

   Contact details (Address & Phone) _____

   _____

   Signature _____

2. Name _____

   Relationship to Child _____

   Contact details (Address & Phone) _____

   _____

   Signature _____

3. Name _____

   Relationship to Child _____

   Contact details (Address & Phone) _____

   _____

   Signature _____

If you have sole legal guardianship assigned by the Court, or Court approval for this referral, please attach a copy of the documentation of this for our files. Please note that without consent of all legal guardians, this referral is unable to proceed.

Referrer's name	

On receiving the referral we will reply to acknowledge receipt of this. Then we will get in contact with you within 3 weeks to discuss if we are the most appropriate service to meet your needs.