Te Pou Oranga o Te Whakatōhea	REFERRAL FORM	Policy #	SD3.2a
		Version #	1
		Date	10/03/2025

Date of Referral:		
Type of Referral:	**Referring to Internal Service**	
	Referring to External Service	
	External Service referring to Te Pou Oranga o Te Whakatōhea	
Referral From: *(Name of internal or External Agency)*		

Please indicate what service/s you are referring to. If unknown Practice Manager will allocate accordingly.

Needs Assessment & Services Coordination		*Community Travel Fund*	
Adult Peer Support		*Family Start*	
Community Based AOD Specialist		*Kaiarahi Navigator*	
Infant, Child, Adlescent & Youth Clinical Services		*Elderly Abuse*	
Specialist Youth AOD Service		*Kowhai Kaumatua Group*	
Peer Support Service for Children & Youth (ICAY)		*Whanau Ora - Health Promoter*	
Kaupapa Māori Community Mental Health		*Whanau Resilience - Domestic Violence*	
Co-Existing Disorders		*Social Workers in Schools*	
Family/Whanau Support		*Rangatahi Whanau Support*	
Adult Community Support		*Oranga Rangatahi*	
Toi Kaiawha		*Rheumatic Fever Prevention*	
Kaupapa Crises Lead		*Well Child/Tamariki Ora*	
Parenting & Pregnancy		*Te Pou Oranga Whaiora*	
Hapainga		*Other:*	

Whanau (Client) Name:		**NHI/NSN**		**Gender:**	
		DOB:		**Age:**	
Address:		**Home :**			
		Mobile:			
Email:					
Preferred Method of Contact	**Text Home Visit Phone Email Other (Please state)**				
Caregiver:		**Relationship:**			
Doctor:		**Phone:**			

Risk Level	Low	Medium*	High	Brief Intervention
Reason for referral:				
Any other information:				
Referred By:		Position:		
Referrer Signature				
*Client being referred must consent & sign before referral will be accepted				
Signature of Client:				
Signature of Caregiver: *(If client is 17 years of age & under)*				
Team Lead Signature:		Date:		

PLEASE FORWARD COMPLETED REFERRAL FORMS TO;

tpowreferrals@whakatohea.co.nz

OFFICE USE ONLY	
Referral Received Date:	
Referral Received by, Staff Name:	*Signature:*
Referral Status: Accepted / Declined (with reason):	