TE POU ORANGA O WHAKATŌHEA

Whānau Ora, Hapū Ora, Ka Ora ai te Iwi

Te Tari Matua o Te Pou Oranga o Whakatohea

SERVICE REFERRAL FORM – PLEASE COMPLETE ALL AREAS WHERE POSSIBLE								
Date of Referral:								
Type of Referral:	☐ **Referring to Internal** ☐ **Referring to External Service** ☐ **External referring to Whakatohea Social & Health Services/Pouawhitia/Workforce/WEAP** *(Please circle department)*							
Referral From / To: *(Name of internal or External Agency)*								
Referral From / To: *(Please indicate what service you would like to refer client to. If unknown please leave blank & the Practice leader will ensure appropriate service is assigned)*	☐	Adult Mental Health Peer Support	☐	Co Existing Disorders Clinician	☐	Kaumatua Service		
	☐	Adult Mental Health Whanau Support	☐	Mental Health Clinician	☐	General Social Services		
	☐	Alcohol & Other Drug Clinician	☐	Rheumatic Fever	☐	Domestic Violence		
	☐	Needs Assessment & Service Coordination	☐	Well Child /Tamariki Ora	☐	Social Worker In Schools		
	☐	Infant/Child/Adolescent/ Youth	☐	Rangatahi	☐	Kaiarahi		
	☐	AOD Rangatahi	☐	Family Start	☐	WEAP		
	☐	Whanau Ora Health Promotion & Education	☐	Pouawhitia	☐	Workforce		
Whanau (Client) Name:			**NHI/NSN**		**GENDER:**			
			DOB:		**AGE:**			
Address:			**Home :**					
			Mobile:					
National Student Number			**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)***								
Practice Leader Signature:			**Date:**					