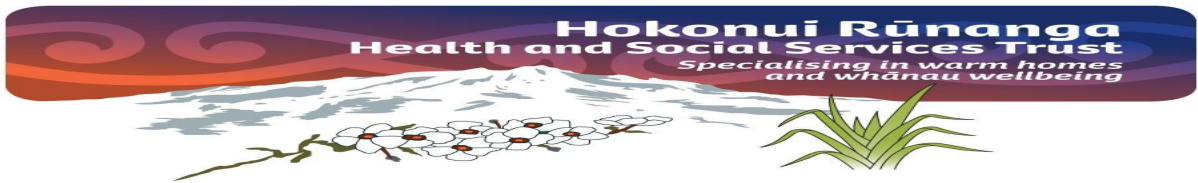


Hokonui Runanga Referral Form

Client Details									
NHI Number:	Is client aware of this referral:								
Surname:	First Name:								
Address:	Phone:								
	Mobile:								
Date of Birth:	Email:								
Age:	Gender:								
Ethnicity:	Iwi/Hapu:								
Parent/Guardian:									
Agency Details									
Agency Address:	Phone:								
	Fax:								
Workers Name:	Workers Mobile:								
	Workers Email:								
<p>What areas does the person need Community Support Service to assist with?</p> <table border="0"> <tr> <td><input type="checkbox"/> Community Health Worker</td> <td><input type="checkbox"/> Counselling</td> </tr> <tr> <td><input type="checkbox"/> Whanau Ora Navigators</td> <td><input type="checkbox"/> Advocacy and Support</td> </tr> <tr> <td><input type="checkbox"/> Youth Work</td> <td><input type="checkbox"/> Cultural Assessment</td> </tr> <tr> <td><input type="checkbox"/> Social Services</td> <td><input type="checkbox"/> Other</td> </tr> </table>		<input type="checkbox"/> Community Health Worker	<input type="checkbox"/> Counselling	<input type="checkbox"/> Whanau Ora Navigators	<input type="checkbox"/> Advocacy and Support	<input type="checkbox"/> Youth Work	<input type="checkbox"/> Cultural Assessment	<input type="checkbox"/> Social Services	<input type="checkbox"/> Other
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<input type="checkbox"/> Youth Work	<input type="checkbox"/> Cultural Assessment								
<input type="checkbox"/> Social Services	<input type="checkbox"/> Other								



Safety Concerns / Mental Health Status:

Reason for referral / Notes:



Received Information Pack: Service Information, Code of Rights, Advocacy Information and Complaints Procedure	Yes / No
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Signature:	Date:
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Office use only:	Received Date:	Processed Date: Referrer Notified:	Signed:
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