Hokonui Rūnanga Health and Social Services Trust

Referral Form

Client details

NHI Number: ______________________

Is client aware of this referral? Y / N

Surname: ______________________

First name: ______________________

Address: ______________________

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Phone: ______________________

Mobile: ______________________

Date of birth: ______________________

Email: ______________________

Age: ______________________

Gender: ______________________

Ethnicity: ______________________

Iwi/Hapū: ______________________

Parent/Guardian: ______________________

Agency details

Agency address: ______________________

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Phone: ______________________

Fax: ______________________

Worker's mobile: ______________________

Worker's email: ______________________

Worker's name: ______________________

What areas does the person need Community Support Service to assist with?

- ❑ Community Health Worker
- ❑ Whānau Ora Navigators
- ❑ Youth Work
- ❑ Social Services
- ❑ Counselling
- ❑ Advocacy and Support
- ❑ Cultural Assessment
- ❑ Other: ______________________

Safety concerns / mental health status:

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Reason for referral / notes:

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Received information pack: Yes / No Service information | Code of Rights | Advocacy Information | Complaints Procedure		**Signature:** **Date:**	
Office use only:	**Date received:**	**Date processed:** **Referrer notified:**	**Signed:**

Email or post completed forms to:

hokonui.office@ngaitahu.iwi.nz

Referrals, Hokonui Rūnanga, PO Box 114, Gore