Te Kete Hauora o Rangitāne
Health & Social Services

Te Kete Hauora o Rangitāne Limited-Referral Form

Personal information-Whānau member/Client	Kaimahi Completing Form:
*First Name: Middle Name: Last Name:	*Address Street: Town:
NHI	Postal address *(if different from above)*
*DOB	Phone
*Gender	Email
*Ethnicity	GP
Alternative contact name	Alternative contact details and relationship to you

Insert Additional Whānau here (if referring to service)

Name	DOB	NHI	Gender	Contact details	Relationship to KWM

Referral Source: *(please circle)* **Self** **External**

External Referrer details:	
Referrer name	Date of Referral
Service	Email

Address	**Phone**
Identified risks *(eg. Animals on property, gang affiliation, things that our staff may need to be aware of)*	
Reason for Referral for both Whānau Member and Additional Whānau	
Consent to Referral (Please indicate)	
Consent to this referral and engagement with Te Kete Hauora o Rangitāne services	
Tobacco use (Please tick)	
Current smoker	
Ex-smoker	
Never smoked	
Would you like a referral to our Smoking cessation service	

Client Signature ____________________ Date ____________

****If under 16 years of age or If signing on behalf of client (if client unable to sign)***

Relationship to client *(parent/guardian / on behalf of)* ____________________ Signature ____________________ Date ____________________ ____________ Name

Please forward completed referral to:
PO Box 62
Dannevirke
Fax: 06 374 5209

Or deliver to:
10 Gordon Street
Dannevirke

PLEASE NOTE THIS REFERRAL CAN NOT BE ACCEPTED UNLESS CONSENT HAS BEEN GIVEN