

WHIRINAKI REFERRAL FORM

Phone: 09 265 4000

Fax: 09 265 4199

Date: _____

YOUNG PERSONS DETAILS:	PARENT/CAREGIVER DETAILS:
Surname: _____	Surname: _____
First Name/s _____	First Name: _____
DOB: _____ Gender: _____	Ph: (Hm) _____ (Mob) _____
NHI: _____	Email: _____
Ethnicity: _____	Dog at home: Y/N _____ Transport: Y/N _____
Language Spoken: _____	Ethnicity: _____
Address: _____	Language Spoken: _____
_____	Address: _____
Mobile ph: _____	_____

Who is the client currently living with (plus contact details)? _____

GP: _____ Ph: _____

School: _____ Ph: _____

Country of Birth: _____ NZ Resident: Y / N Date of Entry into NZ: _____
(if known)

Concerns: _____

Duration of Concerns: _____

Why are you referring to Whirinaki at this time? _____

Is the child/young person at immediate risk? Y N

If Yes, what is the risk: _____

Does the child/young person know of this referral and the information contained in it?	Y	N
Do the parents/caregivers know of this referral and the information contained in it?	Y	N

REFERRERS DETAILS:

Name: _____ Agency/Organisation: _____

Role: _____ Contact Details: _____

OTHER AGENCIES ALREADY INVOLVED AND CONTACT DETAILS

CYFS MoE/RTL SGC Others _____ (specify)

Contact details: _____