**Referral Form (email back to** [**admin@avaniu.co.nz**](mailto:admin@avaniu.co.nz)**)**

**Service referred to:**

* **Ala Mai Early Childhood Whanau Support**
* **Community Connections Support**
* **Matua Lelei**
* **General Enquiry**

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| **Referrer Name:** | **Organisation:** | **Contact Details:** |
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| **Client/Whanau Referral Details:** | | |
| **Family Name:** | **Client Name:**  **D.O.B.:**  **Gender: Female / Male** | **Ethnic Group/s Family Identify with:** |
| **Primary Carer & Relationship to Child:**  ***(pls complete if child/young person under 16yrs)*** | **Consent for Referral: Y/N**  **Primary Carer Aware of Referral: Y / N**  **Primary Carer Consented to Referral: Y / N** | |
| **Address:** | **Reason for Referral:** | |
| **Phone Contact:** |
| **Next of Kin/Alternative Contact Person:** |
| **Contact Details:** | **Name of Doctor & Contact Details:** | |
| **Relationship to Child:** | **Name of Well Child Provider & Contact Details: *(please complete if child under 5yrs)*** | |

**Office Use Only: Date Referral Received: Referral Accepted: Y / N Referrer Informed: Y/N**

**Alternative option recommended to Referrer: Entered into CMS:**