*Please note: This referral may not be accepted if all details are not provided.*

First Name……………………………………………………………Last Name………………………………………………………………….

Address……………………………………………………………………………………………………………………………………………….

Phone………………………………………………Email…………………………………………………………………………………………..

Date of Birth ………………………… Age ………. Ethnicity………………………………………… Iwi ……………………………………...

Current Medical Centre …………………………………………………………………………………………………………………………….

NHI# ………………………………. School (if applicable): …………………………………...……………………. Gender M / F

(If applicable)

Primary Caregiver/s Name………………………………………………………………………………………………………………………….

Caregiver Phone Numbers: …….………………………………………………………...……………………………………..…………………

Next of Kin and Contact Number ………………………………………………………………………………………………………………….

(If applicable)

Children’s Names………………………….………….…….…………………………………………………………………

Dates of Birth……………………....……………………………………………………………………………………………

NHI# ………………………………. School (if applicable): …………………………………...……………………. Gender M / F

(For other children please use reverse of this form, or attach another sheet and include children’s details as above)

Referral Date ….…/….…. /….…. Referrer Name ……………………………………………………………………………………………...

Organisation ………………………………………………………………………….Phone Number………….……………………….………..

Referrer Email ……………………………………………………………………………………………………………………………………….

|  |  |  |
| --- | --- | --- |
| **All RWO Services** *(tick each relevant box)* | | |
| **HAUORA** | Māori Mobile Nursing |  |
| Cervical Screening |  |
| Mother & Pēpi / Child Car Seat Rental Scheme / Pēpi Pod |  |
| Whānau Tamariki Ora / Immunisations |  |
| Alcohol and Other Drug Support |  |
| Adult Mental Health Community Support |  |
| Cancer Care Coordinator |  |
| Te Ohu Auahi Mutunga – Quit Smoking |  |
| Child Adolescent & Youth Service (CAYS) |  |
| Disability Support |  |
| Day Activities Programme |  |
| Kaiwhakapuaki Waiora / Health Coach |  |
| Mātanga Whai Ora / Health Intervention Practitioner |  |
| Lactation Consultant |  |
| Child Birth Educator |  |
| Kaitūhono Care Connector |  |
| Kaiawhina Cancer Care Coordinator |  |
| He Manu Kai Rakau / Wellness Programme |  |
| Te Aro Haurongo / Mindful Focus |  |

|  |  |  |
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| **All RWO Services** *(tick each relevant box)* | | |
| **HE HIKINGA MĀNAWA TOIORA WHĀNAU** | Family Start |  |
| Tikanga Ririki (Traditional Māori Parenting / Te Muka Whānau) |  |
| Social Workers in Schools (S.W.I.S.) |  |
| People For A Brighter Tomorrow (non-violence male) |  |
| Rongo A Whare (non-violence female) |  |
| RWO Navigators (Kaiwhakaaraara) |  |
| Ngā Tini Whetū |  |
| Community Connector |  |
| Counselling (Te Muka Whānau) |  |
| Home-Based Social Work (Te Muka Whānau) |  |
| Whānau Resilience |  |
| Huia Kaimanawa |  |
| Te Pae Oranga (For Police Use Only) |  |
| Kairaranga-A-Whānau (For Oranga Tamariki Use Only) |  |
| Iwi FGC Coordinator (For Oranga Tamariki Use Only) |  |
| **REASON FOR REFERRAL** | | |
|  | | |
| Is the Whānau (client) aware of this referral?                 Yes   /   No  Is the Whānau (client) currently enrolled with Raukawa Whānau Ora Services?            Yes   /   No  If Yes, please list which services ……………………………………………………………………………………………………………..  …………………………………………………………………………………………………………………………………………………….  …………………………………………………………………………………………………………………………………………………….  Scan and email this completed referral to:[**admin@rwo.nz**](mailto:admin@rwo.nz)OR drop it into RWO premises at 152 Bath Street, Levin. | | |

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| --- | --- | --- |
| **Office Use Only** | | |
| Who received this referral? |  | Date: |
| Has the manager received this? |  | Date: |
| Is the referral Accepted or Declined? |  | Waitlist? Yes / No |
| Designated kaimahi is: |  | |