Referral to Parent Aid Waitakere

Referrer to Complete: Date of Referral: _____

REFERRER

Name: _____ Ph: _____

Address: _____ Fax: _____

_____ Email: _____

PATIENT/CLIENT

NHI: _____ D.O.B: _____

Patient/Client Name: _____ Ethnicity _____

Address: _____ Children / Ages: _____

Ph: _____ Mobile: _____ Interpreter Required ◯ Yes ◯ No

Email: _____ GP/Medical Practice _____

Reason for Referral:

Detail all agencies currently involved with Patient/Client (ie GP, Health, Social Services)

_____ _____

_____ _____

_____ _____

Client Consent Obtained by Referrer: ◯ Yes ◯ No

Are there any safety concerns that we should be aware of?

Criminal Offending ◯ Yes ◯ No

Domestic Violence ◯ Yes ◯ No

Dogs on Property ◯ Yes ◯ No

Significant Mental Illness ◯ Yes ◯ No

Other (Please Specify) ◯ Yes ◯ No

_____

Please forward this referral to Parent Aid Waitakere at parentaid@xtra.co.nz