

Whanau Centre Referral Form

Select the service you require. Please note all referrals will initially be assessed by our Korowai service.

<input type="checkbox"/> Social Work	<input type="checkbox"/> Counselling
<input type="checkbox"/> HIPPY	<input type="checkbox"/> Building Financial Capability
<input type="checkbox"/> Parent Education	<input type="checkbox"/> Break Away Holiday Programme
<input type="checkbox"/> Matua Power	<input type="checkbox"/> Oscar Holiday Programme
<input type="checkbox"/> He Oranga Poutama	<input type="checkbox"/> Early Childhood Education

Client/Whanau Details

Client Name:	D.O.B: AGE:
Parent Name: (if child is client)	
Street Address:	Home Phone Number:
	Mobile Number:
Suburb:	Email:
City: Porirua	Gender:
Ethnicity:	Iwi:
Hapu:	Marae:
GP:	Medical Centre:

Has the client agreed to the referral?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are family members aware of this referral?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is it ok to leave messages when client is not available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does client have any children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, (Client does have children) please provide children's name and DOB.

Child 1 Name:	DOB:
Child 2 Name:	DOB:
Child 3 Name:	DOB:
Child 4 Name:	DOB:
Child 5 Name:	DOB:
Child 6 Name:	DOB:
If you have more than 6 children please tick the box provided <input type="checkbox"/>	

Referrer Information

Referrer Name:	Referral Source:
Contact details: Phone: Email:	Date of Referral:

Is the Client currently enrolled in any other PWC services? Y N	Services enrolled
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Summary of Needs

Current Situation:

Vision: (Outcomes sought)

Signed by Referrer

Date:

Signed by Client/Whanau/Caregiver

Date:

Referral Source (Please tick)									
Internal <input type="checkbox"/>	Walk-in <input type="checkbox"/>	Phone <input type="checkbox"/>	Letter <input type="checkbox"/>	Network <input type="checkbox"/>	Event <input type="checkbox"/>	Email <input type="checkbox"/>	Other <input type="checkbox"/>	School <input type="checkbox"/>	WINZ <input type="checkbox"/>
File Number:					Date Referral Allocated:				
Service Allocation:					Staff Allocation:				
Senior Social Worker:									