Whanau Centre Referral Form

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

☐ Social Work	☐ Counselling
☐ HIPPY	☐ Building Financial Capability
☐ Parent Education	☐ Break Away Holiday Programme
☐ Matua Power	☐ Oscar Holiday Programme
☐ He Oranga Poutama Whānau Resilience	☐ Early Childhood Education
☐ Mana Motuhake	☐ Mana Tane

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?	☐ Yes	☐ No
Are family members aware of this referral?	☐ Yes	☐ No
Is it ok to leave messages when client is not available?	☐ Yes	☐ No
Does client have any children?	☐ Yes	☐ 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:**
If you have more than 5 children please tick the box provided ☐	

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

Summary of Needs

Current Situation:

Vision: (Outcomes sought)

Signed by Referrer **…….....** **Date:**

Signed by Client/Whanau/Caregiver …… **Date:**

Referral Source (Please tick)

Internal ☐	Walk-in ☐	Phone ☐	Letter ☐	Network ☐	Event ☐	Email ☐	Other ☐	School ☐	WINZ ☐

File Number: …… **Date Referral Allocated: ……**

Service Allocation: ……Staff Allocation: ……

Senior Social Worker: ……

Submit a Referral