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**
☐ **Energy Mates**	

Referrer Information

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

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:**

Please tick purpose of referral (More than one can be ticked)

Education ☐	Health ☐	Social ☐	Budgeting ☐	Housing ☐	Parenting ☐	Mental Health ☐	Family Harm ☐	Advocacy ☐	Relationship ☐

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: .....