



## Whanau Ora Team– Nursing Referral Form Toi Tu Child/Youth Health

This free mobile community service is offered to Maori (and Non-Maori with socio-economic disadvantage) aged 0-25 years residing within the Auckland DHB area

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<b>Date of Referral</b> _____	<b><u>Referrer Details</u></b>
<b><u>Child/Youth Details: (Attach Label or enter)</u></b>	Name: _____
Surname: _____	Professional Title: _____
First Name: _____	Address: _____
NHI: _____ Ethnicity _____	Ph Work: _____
DOB: _____ F / M: _____	Mobile: _____
Address: _____	Email: _____
Parent/Guardian Full name: _____	<b><u>Exclusion</u></b>
Email _____	• <b><i>This service does not duplicate services already contracted for by the MOH, ACC or DHB</i></b>
Phone _____ Mob _____	

<b><u>GP Details if different from referrer</u></b>
Name: _____ GP Clinic: _____
Address: _____ Phone _____ Email: _____
<b><u>Consent and Safety</u></b> <b>PLEASE ENSURE YOU GAIN GUARDIAN CONSENT BEFORE REFERRING</b>
Yes/No: Guardian or Youth 16yrs + consents to information sharing between Whanau Ora service and Health Providers involved in care
Yes/No: Home Alerts e.g. Dogs, Drugs
Yes/No: Interpreter required: Language spoken _____
<b><u>Other Services involved:</u></b>
<b><u>Clinical diagnoses and any known social issues:</u></b>
<b><u>Reason for Referral:</u></b>
<b>Please attach the following information to referral if not available on Test safe :</b> Recent appropriate labs; screenings (height, weight etc); Long Term Medications; Allergies; any alerts we should be aware of; discharge from hospital letters.
<b>Thank you for the referral</b>
<b>Please notify us if you don't receive an acknowledgment letter within 5 working days</b>

**Fax/Email referral form to:**

**Email :** [info@tehononga.org.nz](mailto:info@tehononga.org.nz); **Fax:** 09 9730789