



He Oranga Tangata

Ngati Kahu Social & Health Services

Phone (09) 406 1441

PO Box 693

Kaitaia 0441

NORTHLAND

Email: referrals@ngatikahu.co.nz

Client Referral Form

Referred from

OT

TRK

CMH

Self

PHO

GP

Other please name: _____

Person filling in referral: _____ Date: _____

Relationship to client: _____

Client Details:

Name: _____

Address: _____

Postal Address, if different from above: _____

Email: _____

NHI: _____

Phone: (Home):

(Work):

(Mobile):

Ethnicity:

Iwi/Hapu:

Gender: *(tick one)*

Male

Female

DOB:

Age:

Key Worker:

Diagnosis:

Next of Kin:

Phone:

Emergency Contact

Name: _____

Relationship to the client:

Gender: *(tick one)*

Male

Female

Address (If different):

Phone: (Home):

(Work):

(Mobile):

“He Oranga Tangata”

Dependents Details

Name	DOB	Gender	Ethnicity	Relationship to client	Address
	/ /				
	/ /				
	/ /				
	/ /				

Reason for referral:

Attach any supporting information if applicable

Intervention required:

Attach any supporting information if applicable

Is there anything we need to know about current or future situation?

Risk / Potential Risk

Office use only

Date of Referral: ___/___/___

CMS Entered Date: ___/___/___

Service: BFC CSS KMP *please circle all that apply*

Kaimahi Ora Name: _____

Referred To: _____

Ongoing

One Off

Declined

CEO Signed: _____ / ___/___

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