Updated May 2025

Maraeroa Marae
Health Clinic
Ka Ora te Whanau Ka Ora te Iwi
*Strengthening our Families Strengthening our People*

# Referral Form

***Select the service you require. Please note all referrals will be reviewed/screened***

| | |
|---|---|
| ☐ **Hanga Huringa Te Hauora AOD Assessment and Triage service** (Helping whānau and individuals through education, treatment planning and positive recovery outcomes)<br><br>☐ **Nga Kete Aronui Kaupapa Māori Primary Mental Health and Addiction** (To provide services that tautoko and manaaki whānau, hapū and iwi) | ☐ **Whare ki te Whare Kaia Rahi Navigation service** (Supporting Māori to stay healthier at home and are identified as at risk of admission to hospital)<br><br>☐ **Mate Pukupuku Roopu/ Cancer Support** (monthly group and advocacy)<br>☐ Tane Support Group (once a month Monday)<br><br>**Whānau Ora** (health education and advocacy)<br>☐ Kaumatua Exercise (Tinana Korikori) Tuesdays<br>☐ Community support |
| ☐ **Well Child Tamariki Ora** (Supporting Māmā, pēpi and tamariki under five years with well-child checks, breast feeding and well-being. Home nad/or clinic visits) | **Specialist Services:**<br>☐ Optometrist (Ravi: Mr Foureyes)<br>☐ Sleep Well Clinics (Andrew Davies and team)<br>☐ Colposcopy Clinic |

| **Whaiora /Whānau Details** | | |
|---|---|---|
| Name: | D.O.B: | Age: |
| | NHI: | |
| Street address: | Contact Number: | |
| Suburb: | Other Number: | |
| City: | Email Address: | |
| Ethnicity/Ethnicities: | Iwi (tribe/s): | |
| | Hapū (subtribe/s): | |
| Gender: …. Female …. Male …. Other | | |
| Living arrangements, dependents (e.g. partner/Tamariki/mokopuna/other etc.): | | |

| **Emergency Contact/Next of Kin/Carer/EPOA** | |
|---|---|
| Name: | Contact Number: |
| Relationship: | Other Contact: |

Updated May 2025

| **Referrer Details** | |
|---|---|
| Name: | Referral Source (organisation): |
| Contact Number: | Email: |
| Other Contact Number: | Date of Referral: |
| **Medical Details** | |
| Medical Centre/GP Practice: | Contact Number:<br>Email: |
| Does the whaiora consent to the referral?<br>☐ Yes<br>☐ No | Is the medical centre aware of the referral?<br>☐ Yes<br>☐ No |
| Is the referral the result of an accident?<br>☐ Yes<br>☐ No | Date of accident:<br>…… / …… / ……..  ACC claim no: |
| **Other external services involved in care:** | |
| Level of urgency to contact patient<br>☐ Low<br>☐ Medium<br>☐ High | Any safety concerns/risks?<br>☐ No concerns<br>☐ Yes. Please specify: |

| **Mobility** | **Cognition** | **Skin Integrity** | **Sight** | **Communication** |
|---|---|---|---|---|
| ☐ Independent | ☐ Alert and rational | ☐ Intact | ☐ Good | ☐ Good |
| ☐ Stick | ☐ Mildly confused | ☐ Broken | ☐ Impaired | ☐ Impaired |
| ☐ Crutches | ☐ Very confused | **Incontinent** | **Hearing** | **Nutrition** |
| ☐ Frame | | ☐ Urine | ☐ Good | ☐ Good |
| ☐ Wheelchair | | ☐ Bowels | ☐ Impaired | ☐ Impaired |

| **Additional Information – past medical history and current diagnosis** |
|---|
| |
| **Reason for Referral** (please specify) |
| |

**Signed by Referrer:** _____ **Date:** _____

**Signed by Whaiora/Whānau/Caregiver:** _____ **Date:** _____