



Maraeroa Marae Health Clinic

Ka Ora te Whānau 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) ☐ Nga Kete Aronui Kaupapa Māori Primary Mental Health and Addiction (To provide services that tautoko and manaaki whānau, hapū and iwi) ☐ Mirimiri One-on-one appts (Once per month) ☐ Maara Kai Roopu (Tue & Thurs) ☐ Wāhine Toa Roopu (Friday)	☐ Whare ki te Whare Nursing Navigation Service (Supporting whaiora to stay healthier at home and are identified as at risk of admission to hospital) ☐ Mate Pukupuku Roopu/Cancer Support (monthly group and advocacy) ☐ Tane Support Group (once a month Monday) Whānau Ora (health education and advocacy) ☐ Kaumatua Exercise (Tinana Korikori) Tuesdays ☐ Community support Specialist Services: ☐ Sleep Well Clinics (Dr. Andrew Davies & team) ☐ Colposcopy Clinic (Dr. Judy Ormandy) ☐ Optometrist – Eye Specialist	
☐ Well Child Tamariki Ora (Supporting Māmā, pēpi and tamariki under five years with well-child checks, breast feeding and well-being. Home and/or clinic visits)	Whānau Ora Kaiārahi Services ☐ Navigation Support – Advocacy with MSD, Kainga Ora, Housing, Te Ahuru Mōwai, Kai and various Govt Orgs ☐ Rangatahi Education and Employment Pathways	
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:	

Referrer Details				
Name:		Referral Source (organisation):		
Contact Number:		Email:		
Other Contact Number:		Date of Referral:		
Medical Details				
Medical Centre/GP Practice:		Contact Number:		
		Email:		
Does the whaiora consent to the referral? ☐ Yes ☐ No		Is the medical centre aware of the referral? ☐ Yes ☐ No		
Is the referral the result of an accident? ☐ Yes ☐ No		Date of accident: / / ACC claim no:		
Other external services involved in care:				
Level of urgency to contact patient ☐ Low ☐ Medium ☐ High		Any safety concerns/risks? ☐ No concerns ☐ Yes. Please specify:		
Mobility ☐ Independent ☐ Stick ☐ Crutches ☐ Frame ☐ Wheelchair	Cognition ☐ Alert and rational ☐ Mildly confused ☐ Very confused	Skin Integrity ☐ Intact ☐ Broken Incontinent ☐ Urine ☐ Bowels	Sight ☐ Good ☐ Impaired Hearing ☐ Good ☐ Impaired	Communication ☐ Good ☐ Impaired Nutrition ☐ Good ☐ Impaired
Additional Information – past medical history and current diagnosis				
Reason for Referral (please specify)				

Signed by Referrer: _____

Date: _____

Signed by Whaiora/Whānau/Caregiver: _____

Date: _____