Updated Oct 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) ☐ **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) ☐ **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
☐ **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:** ☐ Optometrist (Ravi: Mr Foureyes) ☐ Sleep Well Clinics (Andrew Davies and team) ☐ 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:

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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	**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:** _____