Updated Feb 2026

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) ☐ Pāpā Parenting Programme (Tue Weekly) ☐ Mau Rākau Programme (Weds Weekly)	☐ **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)
☐ **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 (Thurs) ☐ Wāhine Toa Roopu (Friday)	**Māori Community Health** (Kaumātua health education and advocacy) ☐ Kaumātua 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:

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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 ☐ Stick ☐ Crutches ☐ Frame ☐ Wheelchair	☐ Alert and rational ☐ Mildly confused ☐ Very confused	☐ Intact ☐ Broken **Incontinent** ☐ Urine ☐ Bowels	☐ Good ☐ Impaired **Hearing** ☐ Good ☐ Impaired	☐ 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:** _____