Te Whatu Ora l TAIRAWHITI
PRIVATE BAG 7001
GISBORNE
NEW ZEALAND
Phone: 06 869 0500
Fax: 06 869 0573

Health New Zealand
Te Whatu Ora

CHILD DEVELOPMENT SERVICE TAIRAWHITI
TARI WHANAKITANGA TAMARIKI

Referral Form for Children Under 5

PLEASE NOTE: Do not use this referral form if you are sending a referral from school. There is another form for school aged children.

CHILD'S NAME:	
DOB: *AGE:*	*PRESCHOOL:*
HOME PHONE:	*PRESCHOOL PHONE:*
ADDRESS:	*TEACHER:*
CARERS NAME/S:	*REFERRED BY:*
EMAIL:	*ORGANISATION:*
MALE/FEMALE	*EMAIL:*
NHI:	*COMPLETED BY:*
GP:	*DATE:*

REASON FOR REFERRAL:

Please describe the child's strengths:	

Please identify the key things that this child and their whanau needs help with to make life easier for them:	
Relevant known Medical Information:	

If you know that the child has been referred to any of the following services, please highlight/tick and add any other services:

MOE	ICAMHS	Paediatrician	Audiologist	Explore/Kia Roha	Oranga Tamariki
Other:					
Please provide names and designations of those working with this child and whanau: *(SLT/EIT etc)*					

Signed by Referrer: ________________________________

Date: ________________________________

Whanau Consent:

I ………………………………………. give consent for ………………………………………………. School to provide this information regarding my child …………………………………………………………. to the Child Development Service, Te Whatu Ora Tairawhiti, Gisborne Hospital.

Signed: *Date:*

Please scan and email this form to referralcds@tdh.org.nz or post to Team Leader – Child Development Service