



Referral Form

Date: _____ NHI: _____ (leave blank if unsure)

Client name: _____
First Middle Last

Parent name: _____
(If client is under 18) First Middle Last

Ethnicity: _____ NZ Resident/Citizen? Yes No

Preferred Gender: _____ Preferred Pronouns: _____

Date of Birth: _____ Age: _____

Relationship status: _____

Home address: _____

Postal address (if different from above): _____

Best methods to contact you: _____ Can we contact you by this method?

Phone: _____ Yes No

_____ Yes No

Email: _____ Yes No

Can we leave you voicemails? Yes No

Can we text you? Yes No

Emergency contact (name and phone): _____

Relationship to you: _____

Family Doctor or Medical Practice: _____

Can we let your Doctor or Medical Practice know that you are being seen here? Yes No

Who referred you to TPC (can be self)? _____

Thank you for providing this information about yourself and your family as part of a referral. It will help our team to determine how best to proceed with your request for services at our centre. It is possible someone may call you to clarify some of the information.

Optional - please briefly describe why you've come to see a psychologist today:
