



Name: Address DOB Whaiora ID Label

Kia ora
 Thank you for taking the time to complete the information below. This will help our service to better understand your needs and how we can help you? We are working in partnership with other services to ensure your care is connected through a teams of teams approach. What does that mean? This means we can connect with services who can help facilitate your wellbeing needs so you don't need to tell your story multiple times. Your information will be treated with dignity and respect. If you require support to fill in the form or support with language or cultural issues you can do this with your whānau, support person or people you can trust.

Whānau Whaiora	
Name:	Preferred name:
Gender:	Ethnicity:
Gender diverse:	Iwi:
DOB / Age:	
Wairuatanga Spirituality:	
Whānau strengths and/or support:	
Address:	
Postcode:	

Language:	Interpreter needs:
Phone:	Legal Status:
Email:	
Specific needs (communication / disability) e.g. wheelchair access required:	

Alerts (eg. falls risk, security presence required, adverse medication reaction):
Allergies:
COVID vaccination status:
First vaccination completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Fully vaccinated: <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you registered with a GP: <input type="checkbox"/> Yes <input type="checkbox"/> No GP phone number:



GP names & address:

Pharmacy:

Are the connected with a Kaiaaraara whānau ora navigator or Kaiwhakapuaki?

Yes

No

Name & phone number:

Other services currently connected with:

Kaitono referrer by:

Relationship, Designation:

Waea (phone):

Nō/ward or service:

Rāpoto (summary) of referral request:

Relevant wellbeing/clinical background:

Are there AOD concerns, please detail:

Are there safety concerns, please detail:

Date of referral:

Signed:

Whaiora are aware of referral:

Date referral received:

Signed: