TE AKA ORA CHARITABLE TRUST
9 Temple Street, Gisborne • PO Box 2124 Gisborne
(06) 868 7722
Return to: Referrals@ora.org.nz

Social Services Referral

REFERRAL - REGISTRATION FORM

Whanau Support		Social Worker in Schools		Teen Parent Support	
Transition Support		Te Aka Ora House		Other	

CLIENT DETAILS: Date: ____/____/20____

Name:______________________________ **Partner/Spouse:** ______________________________

Address: ____

Phone: ______________________________ **D.O.B:** __________ **Gender:**__________ **Age:**_______

Ethnicity: ___________________________ **Iwi:** ____

Employed: ___________________________ **Benefit:** ______________________________________

School: ______________________________ **WINZ number:** _________________________________

WHANAU INFORMATION (Spouse/Tamariki /Siblings)

Name	DOB/Age	Relationship	School/Kohanga/Training

REFERRING AGENCY DETAILS

Referral from: ***(Agency)***______________________**Ph:**_____________ **Email:**_______________

Contact Person: _____________________ **Address:** _____________________________________

A) Reason for Referral: ____

____

B) Underlying Issues: ____

____

C) Background History: ____

____

D) Agencies Goals for Referral: ____

E) Other Agencies Involved: ____

____

This information will be kept strictly confidential. NZ community funding agency reserves the right to examine any documents or records held by this organization. However identification of individuals will be protected.

I am aware of this referral and I consent to it being made: ________________________________

Client Signature **Date**

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Confidentiality Agreement

Client/Student: ______________________________

Address: ______________________________

____

All discussions with the Te Aka Ora Charitable Trust Worker(s) are ***confidential.***

No discussion or reports will be given to other people without you knowing.

The only time the Te Aka Ora Charitable Trust Worker(s) will talk to someone else about you is when they have concerns about your safety. Times when:

1) You may hurt your self
2) Someone may hurt you
3) You may hurt someone else

Client's Signature: ______________________

Date: ______________________

OFFICE USE ONLY:

Reference No: _________ **Assigned to:** ________________________

Manager Approved: ____________________ **Date:** / / 20

Outcome Notes:

Criteria Met TAOH: (Section number)