Referral – Wellchild Tamariki Ora Enrolment Request

Community Child & Youth Health Services

Tauranga Fax: 07 578 5485 Whakatane Fax: 07 306 0987

If you are a MAC user the "submit email" function may not work. Please fill in details, print then FAX your referral

Referrer Details:

Organisation Name:		Referral Date:	
Referrer Name:		Referrer Phone:	
Referrer Position:		Email Address:	

Parent/Caregiver Details:

First name:		Surname:	
Residential Address:		Home Phone:	
Postal Address:		Mobile Phone No:	
Email Address:		Consent to Referral (*select*):	

Has the parent/caregiver indicated a preferred wellchild tamariki ora provider? If so please write information below.

Child's Details:

First name:		Surname:	
Date of Birth:		NHI:	
Gender (*select*):	*Male*	Ethnicity (*select*):	*Other*

Reason for referral and any other relevant information (*summary only*):

Desired Outcome:

PRINT FORM **EMAIL to BOPDHB Wellchild Enrolment Co-ordinator** **CLEAR FORM**

Wellchild Tamariki Ora Enrolment Co-ordinator to complete the below	
Date referral received:	
Date contact is made and/or appointment made:	
Date child is successfully enrolled in a Wellchild Tamariki Ora provider:	