Te Whatu Ora
Health New Zealand
Hauora a Toi Bay of Plenty

# 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. |
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| |

**Child's Details:**

| | | | |
|---|---|---|---|
| First name: | | Surname: | |
| Date of Birth: | | NHI: | |
| Gender (*select*): | | Ethnicity (*select*): | |

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

| **Desired Outcome:** |
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| |

| **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: | |

NOTE: The electronic version of this document is the most current. Any printed copy cannot be assumed to be the current version.