Whanau Cente Referral Form

Please complete this referral with as much detail as possible. All referrals will be assessed by our Korowai intake team

Service Required

Whanau Support ☐ Counseling ☐ Matua Power ☐

Parent Education ☐ Budgeting ☐ HIPPY ☐ Kainga Ora ☐

Oscar Holiday Programme ☐ Breakaway Holiday Programme ☐

Whanau Details

Client Name D.O.B Age

Street Address Home No

Mobile No

Ethnicity Maori Iwi

Hapu Marae

Medical Centre GP

If client is15 and under, please list Parents full name

Referrer Details

Referrer Name Referrer Organisation

Contact Details

Phone Email

Date of Referral

Is the Client enrolled in any other Porirua Whana Centre services? No

If Yes please name the service/s

Whanau Centre Referral Form

Please complete this referral with as much detail as possible. All referrals will be assessed by our Korowai intake team

The following section is to gain an understanding on the clients needs and aspirations. Please provide as much detail as possible so we are able to provide a tailored response

Select purpose of referral (you can select multiple if required)

Social Needs ☐ Budgeting ☐ Housing ☐ Mental Health ☐ Health ☐

Parenting ☐ Relationships ☐ Advocacy ☐ Family Harm ☐

Summary of Needs

Please outline the clients current situation

Please advise the outcomes and aspirations being sought

Submit Referral

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