Referral Form

Earthlink.Inc supports and works with clients with primarily mental health, addiction and related disability concerns.

ALL PARTS OF THIS FORM MUST BE COMPLETED BEFORE RETURNING TO Earthlink.Inc

Referring Agency details Date……/……./…….

Name of Agency……

Contact Person…….. Phone #……..Cell #.....

Referral Clients details: PLEASE STATE FULL NAMES AS THEY APPEAR ON LEGAL DOCUMENTS INCLUDING MIDDLE NAMES AND ALIAS NAMES IF APPLICABLE

Name…… D.O.B……/……/…….

Address…… Ph#.....

Email…… Cell#.....

Emergency Contact name/relationship……

Emergency Contact Ph#.....

Ethnicity…….. Iwi…….

Work & Income Benefit Type…….. Client #.....

Disability…….. Smoker…….. Non-Smoker……...

Key Support Worker…… GP…….

I agree that the information as shown above is true and correct

Clients Signature…….. Date…../…../…….

Please bring this form to your first appointment or scan and email it to alison@earthlink.org.nz

The Clients signature must be completed on this referral to comply with the Privacy Act 1981

Office Use Only	
Date of receipt…../…../…..	Sign…….
NHI……..	