Referral Form

Diagnosis information must be attached BEFORE sending

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

Name of Agency……

Contact Person…….. Phone……..Mobile.....

Email address……

N.B. Client must be over 18 years of age and diagnosed with a mental health condition

Clients details: PLEASE STATE NAMES AS THEY APPEAR ON LEGAL DOCUMENTS

Name…… D.O.B……/……/…….

Address…… Phone.....

Email…… Mobile.....

Gender…….. Pronouns……..

Ethnicity…….. **Iwi**……...

Mental Health Diagnosis (and/or Addiction)

……

WINZ benefit type (circle) Job seeker or SLP

Emergency Contact, Name.....

Relationship to you……

Emergency Contact Phone.....

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

Clients Signature…….. Date…../…../…….

Bring this form to your appointment or scan and email it to: training@earthlink.org.nz

Clients signature must be completed on this referral to comply with the Privacy Act 2020.

Office Use Only

Date of receipt…../…../…... NHI……..

Referral status. Accepted/Declined. Name: Signature……

Designation:

25 Peterkin Street, Wingate, Lower Hutt. Phone: 04 567 7111. P O Box 40886 Upper Hutt