

Rainbow Place Family Services Referral



This referral is: Urgent (24hr response during week days)
 Routine (72hr response)

Referral Date: _____

If this referral requires an urgent response, please telephone Rainbow Place to discuss it further with clinical staff:
 Telephone: (07) 859 3848 Fax: (07) 859 1266

Please complete both pages of referral form

Details of children/young people being referred

Name (in full)	Age	Gender	NHI (if known)	Relationship to seriously ill / deceased person

Contact information

Address: _____
 City/Town: _____ Post code: _____
 Telephone: _____ Mobile phone: _____
 Ethnicity: _____ First language: _____
 Religion: _____ NZ Resident: Yes No

Reason(s) for referral:

Child/young person agreed to referral: Yes No Parent(s)/Guardian agreed to referral: Yes No

By agreeing to this referral the child/young person and/or parent/guardian gives Rainbow Place permission to request further relevant health information from other health care providers as required to process this referral.

Information regarding seriously ill/deceased person

Surname: _____ NHI No: _____
 First Name(s): _____ DOB: _____ / ____ / ____
 Gender: M F Ethnicity: _____
 Diagnosis: _____
 Hospice Waikato patient? Yes No Deceased? Yes No (Date: _____)

General Practitioner details

GP Name of GP: _____
 Practice Name and Address: _____
 Telephone: _____
 Fax: _____ E-mail: _____

