



# REFERRAL / ENQUIRY FORM

PO Box 325  
Waikato Mail Centre  
Hamilton 3240  
Phone (07) 859 3848  
Fax (07) 859 3847

Date: .....

Name of child/young person referred				
NAME (include surname)	M/F	DOB	ETHNICITY	RELATIONSHIP TO PATIENT

Address: .....

Phone: .....

.....

Mobile: .....

Post code: .....

E-mail: .....

Parent(s) / Caregiver(s): .....

Child/ren live with: .....

Reason for referral / Area of concern: .....

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.....

## Information regarding patient / significant other (if different from above)

Patient Name: .....

NHI Number: .....

Hospice Patient: No  Yes  If yes, Hospice client number: ..... Relationship to client: .....

If deceased, date of death: ..... GP: ..... Consultant: .....

Other professionals / agencies involved: .....

How did you hear about our service? .....

Referred by: .....

Role: .....

Organisation: .....

Phone: .....

Fax: .....

E-Mail: .....

Is the family aware of the referral and given consent? Yes  No

Signature of referrer: ..... Date: .....

## Action taken by Rainbow Place:

EOS booked

Date: .....

Staff member: .....

\*Doesn't meet criteria

\*Enquiry only

\*Reason for above decision .....

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