Waitemata District Health Board

Best Care for Everyone

Child, Women & Family Service

Child & Family Referral - CONFIDENTIAL

Date of referral :	**Referred by:** Phone contact:
Surname: **First name:** A.K.A: Male/Female DOB: Ethnicity:	**School/Preschool**: **RTLB/GSE involvement? Yes/No** *If Yes, contact's name is:*
Mothers name : Address: Phone: Mobile: Child's address? Y/N	**Fathers name:** Address: Phone: Mobile: Child's address? Y/N
Siblings:	**Alternative contact**: Address: Ph: Relationship to child: Child's address? Y/N
Referral for: (please circle) Public health nurse Social Worker Ear nurse specialist Vision hearing technician Medical officer	**GP:** **Agencies involved with family:** **Alerts: e.g dogs/allergies**:

Issue requiring Child & Family involvement:

Consent by family/young person for this referral? Yes/ No

Duration of Concerns:

Has this issue been discussed with the parents/ caregiver? Yes/ No (If no, please indicate reason)

What interventions, assessments have already been suggested or tried?

What do you hope will be achieved through our intervention?

Date Received : **Staff member:**

Contact details for referrals:

Child Health Referral Service

Phone: 0800 247 333

Fax: 09 837 8877

Email childhealthreferrals@waitematadhb.govt.nz