wellingtoncitymission

EXTERNAL REFERRAL FORM – COMMUNITY SERVICES
Please send completed form to Referral@WCM.org.nz

- *The information on this form helps our team provide you with the best possible service.*
- *The information is voluntary.*
- *This information will be kept confidential except if there is a safety concern.*
- *If you need help to fill out this form or have any questions or concerns, please do not hesitate to ask.*
- *NB AGENCIES: By signing this form on the persons behalf, the person has agreed to information being shared.*

Date 2/16/24

Name of Referring Agency and Referring Person _____

Telephone _____

Email _____

Client or Agency signature (to agree for referral)_____

WCM Team member completing this referral _____

Has the client been notified/aware of the referral? yes [ ] no [ ]

Client Name _____ **Gender**: _____ **D.O.B**……

Contact Telephone _____

Address (if they have one) _____

_____

MSD Number: _____

Country of Birth:_____**Ethnicity**:_____

IWI:_____

Housing situation: Kainga Ora (HNZ)

Other_____

Can person speak / understand English yes ◯ limited ◯ no ◉

Other languages spoken: _____

Relationship/Family:

Partner name: _____

Child within household - name:_____DOB……

So that we can best assign the best supports please complete the following summary with as much info:

What are the support needs?

Are you engaged with other services- health, mental health, support providers (and if this is an agency referral, what ongoing assistance will your agency have with this client?)

Are there any other issues or concerns that have not been mentioned?
(E.g. Family Violence; Relationship; Parenting; Mental Health; Isolation; Abuse & Neglect; Trauma; Addictions eg.Drugs & Alcohol or Gambling; Financial; Housing issues)

The Mission covers the region of Wellington City, Hutt and Upper Hutt City boundaries

Thank you for providing us with the above information as it will assist in our assessment process.