



# Mai Lighthouse

Guiding whānau to wellbeing

## Client Referral Form

Date in:	Date referred:	To:	Client no:
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PERSONAL DETAILS	
NAME:	DOB:
ADDRESS:	
HOME PHONE:	MOBILE:
ETHNICITY:	GENDER:
IWI:	
COUNTRY OF BIRTH:	
EMAIL ADDRESS:	
ALTERNATIVE CONTACT NAME:	PHONE:

### Immediate Service

Are you having thoughts about dying or feel at risk of self-harm or suicide?

### Social services

Family harm

Concerns and issues for individuals, whānau/families

Oho Wāhine –for women affected by harm, mental health and or addictions (4 week)

Aged 65yrs and over experiencing or at risk of abuse/harm or neglect

Te Huringa o Te Ao - supporting sustainable behaviour change for men to restore whānau wellbeing.

### Parenting Programmes

**Incredible Years 3 – 8 years**  
for parents/caregivers with children 3 – 8 years

**Parenting Toolbox for teens**  
6 week course for parents of teenagers 12 – 18 years

### Financial Mentoring

*Please circle if applicable*

Eviction    Disconnection    Debts  
Re-possession    Rent    Future Planning  
On-going budgeting support  
Kiwi Saver withdrawal

### Counselling

I would like to resolve issues and reach decisions. Work through loss, resolve and put to rest concerns, past trauma, anxiety, depression and anger. Add meaning to life.

My child/ren has/have witnessed violence and/or a disruptive home environment (5-18yrs)

### Transport

Transport to and from Hospital appointments.  
(48 hrs notice is required)



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Please provide any details that might help the team to further support you and or your whaanau:


## Children Details

Child Name	DOB	Gender

## Referrer details

Have you (referrer) obtained consent from the whaanau to make this referral		Yes / No
Referrer name		
Referrer organisation		
Phone		
Email		

### ***Informed Consent:***

*I understand this referral will go to the Mai Lighthouse team so they can work together to provide the best support available. Confidentiality is maintained within the team.*

**PRINT NAME:** .....

**SIGNED:** .....