Mai Lighthouse
Guiding whānau to wellbeing

Client Referral Form

Date in:	Date referred:	To:	Client no:

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, whaanau/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 ō Te Ao - supporting sustainable behaviour change for men to restore whānau wellbeing.	

Counselling

My child/ren has/have witnessed violence and/or a disruptive home environment (6-18yrs)	

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	

Medical Transport

Transport to and from Hospital appointments. *(48 hrs notice is required)* **CSC or GOLD CARD Number:**	

Address: 205 King Street, Pukekohe, 2120
Phone: (09) 238 6233
Email: admin@mailighthouse.org.nz

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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: .....