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# Referral Form **Te Hononga me te Pūtea Puka Whakawhiti**

Your Way | Kia Roha provides disability support services to eligible people living within New Zealand. Please complete this form if you wish to refer someone to our Connections & Funding service e.g. a patient, someone you’re working with. Please note that you must have the person’s permission to make a referral on their behalf, or that of a parent / guardian if the child or young person referred is under 18 years old. There are eight sections.

Disabled people and parents of disabled children can refer using [Your Way | Kia Roha Connections & Funding Self-referral Form](https://g9e2p3m7.rocketcdn.me/wp-content/uploads/2022/11/Your-Way-Kia-Roha-Referral-Form.docx).

If you need assistance with the form or have questions about our referral process, please contact our team on 0800 758 700 or email [referrals@yourwaykiaroha.nz](mailto:referrals@yourwaykiaroha.nz)

If it’s the first time we have received a referral from you, we will also need:

* The referred person’s GP / medical specialist to complete the Confirmation of Disability Form which can be downloaded here [Make a referral - Your Way | Kia Roha (yourwaykiaroha.nz)](https://www.yourwaykiaroha.nz/connections-funding/make-a-referral/)
* Specialist reports if the person has an intellectual disability or Autism Spectrum Disorder.

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| Section 1 - About the person being referred |

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| **First name / s**  Type your answer here: |

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| **Surname**  Type your answer here: |

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| **Title** – Mr / Mrs / Ms / Miss / Master / etc.  Type your answer here: |

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| **Preferred name** (to be used when we contact you)  Type your answer here: |

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| **Address**  Type your answer here: |

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| **Telephone or mobile number**  Type your answer here: |

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| **Email address**  Type your answer here: |

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| **I prefer that you contact me by email / phone / text**  Type your answer here: |

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| **Date of birth (day / month / year)**  Type your answer here:  **Gender** – please choose from the following options and type in the box below. Female / Male / Non-Binary / Transgender man / Transgender woman / Agender /  Prefer not to say / Other  Type your answer here: |

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| **Pronoun** – please choose from the following options and type in the box below. She / He / They  Type your answer here: |

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| **Residency Status** – please choose from the following options and type in the box below. NZ Citizen / NZ Resident (date of residency) / Non-NZ Resident (please provide information on your residency / visitor status)  Type your answer here: |

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| **Ethnicity** – please choose from the following options and type in the box below. Māori (Iwi / hapū) / NZ European / European / Asian / Pāsifika (Island / Islands) / Other  Type your answer here: |

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| **First language** – if not English  Type your answer here: |

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| **Interpreter required** – Yes / No  Type your answer here: |

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| **Is cultural support required** – No / Yes (provided by me) / Yes (provided by  Your Way | Kia Roha). Please explain support required.  Type your answer here: |

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| **Communication needs Your Way | Kia Roha should be aware of when working with the person referred** – No / NZSL / Other  Type your answer here: |

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| Section 2 - The Person’s Medical Information |
| **Doctor / GP name**  Type your answer here: |

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| **Doctor / Medical Centre address**  Type your answer here: |

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| **Doctor / Medical Centre telephone number (required)**  Type your answer here: |

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| **National Health Index (NHI) number, if known**  Type your answer here: |

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| Section 3 - The Person’s Disability Information |

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| **Disability name / type**  Type your answer here: |

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| **Other medical / health issues (if any)**  Type your answer here: |

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| **Reasons for referral**  Type your answer here: |

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| **Supports / service the person would like (if known)** Information about services and supports / Connection with services and support / Development of a Living Well Plan with me / Unsure  Type your answer here: |

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| **The services / supports are:** Urgent (required within one week) / Semi-urgent (required within four weeks) / Non-urgent  Type your answer here: |

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| Section 4 - Additional Information |

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| **Safety, hazards or other sensitive issues Your Way | Kia Roha should be aware of when working with the person referred**  Type your answer here: |

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| **Any other important information Your Way | Kia Roha should know about the person referred** – No / Yes (please provide information)  Type your answer here: |

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| Section 5 - Alternate Contact (optional) unless referring a child or young person under 18 years, then please include contact details for the parent or guardian. |

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| **Please complete if there is someone we should contact if we’re unable to reach you** – Name, Contact phone number, Email, Relationship  Type your answer here: |

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| Section 6 - Referrer’s contact details |

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| **Name and contact of referrer** – Name, Contact phone number, Email, Relationship to the person referred  Type your answer here: |

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| Section 7 - Consent and Privacy Statement  (please type in each statement to show consent) |

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| **The person referred, or their guardian or parent (if under 18 years), has given me permission to provide all information contained on this Referral so  Your Way | Kia Roha can assess her / his eligibility for services.** – Yes / No  Type your answer here: |

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| **I understand that the information I have provided will be shared with relevant  Your Way | Kia Roha employees, Whaikaha – Ministry of Disabled People and other professionals to assess the person’s eligibility for services.** – Yes / No  Type your answer here: |

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| **I understand that both the person referred, and I may be contacted to verify my right to provide information and to obtain additional information required to assist in the assessment process.** – Yes / No  Type your answer here: |

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| **I understand information such as ethnicity and age may be collected for statistical purposes and shared with the Ministry as part of Your Way | Kia Roha reporting.** – Yes / No  Type your answer here: |

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| **I understand the person referred can ask for copies of all the information I have provided and correct any information that is wrong.** – Yes / No  Type your answer here: |

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| Section 8 - Signatory |

## **You have now reached the end of the document. Please sign and date below.**

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| **My signature (or name if unable to sign)**  Type your answer here: |

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| **Name of parent / guardian completing (if on behalf of a child)**  Type your answer here: |

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| **Date referral completed**  Type your answer here: |

Thank you for your referral. We will contact you within five working days if we require more information or to let you know the outcome of your referral. If you haven’t heard from us within five working days, please email us at [referrals@yourwaykiaroha.nz](mailto:referrals@yourwaykiaroha.nz) or phone us on

**0800 758 700**.