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# Self-Referral **Te Hononga me te Pūtea Puka Whakawhiti**

Your Way | Kia Roha provides disability support services to eligible people living within New Zealand. If you wish to access our services yourself (or for your child), please complete this Referral Form. There are seven sections.

If completing for a child, include their information as if they were completing the form.

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:

* Your 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/)
* Any specialist reports (such as intellectual disability, or Autism Spectrum Disorder)

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| Section 1 - About Me |

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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: |
| **Date of birth (day / month / year)**  Type your answer here: |

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

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| **I have communication needs Your Way | Kia Roha should be aware of when working with me** – Yes / No / NZSL / Other. Please tell us about your needs.  Type your answer here: |

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| Section 2 - 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 - 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 I am seeking support / services**  Type your answer here: |

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| **Supports / services I would like** 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 I need 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 me**  Type your answer here: |

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

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| Section 5 - Alternate ContactThis section is optional unless you are the parent / guardian of a child or young person aged under 18 years, then please complete with your details. |

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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 - Consent and Privacy Statement(Please type in each statement to show consent) |

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| **I give you permission to use the information I have provided on this Referral Form to assess my eligibility for services from Your Way | Kia Roha.**  – Yes / No  Type your answer here: |

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| **I understand that the information will be shared with relevant Your Way | Kia Roha employees and that it may be shared with Whaikaha – Ministry of Disabled People and medical professionals to assess my eligibility for services from  Your Way | Kia Roha.** – 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 I can ask for copies of all the information and if I think the information is wrong, I can ask for it to be corrected.** – Yes / No  Type your answer here: |

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| Section 7 - 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**.