Village Collective Clinic - Referral Form

Referrer Information

Name	
Organization (if applicable)	
Role/Relationship to client	
Phone Number	
Email Address	

Client Information

Full Name	
Date of Birth	
NHI Number (if known)	
Gender	
Trans / Non-Binary / Another Gender	Yes / No / Not Sure
Ethnicity / Cultural Identity	
Preferred Language	
Interpreter Required?	
Address	
Phone Number	
Email Address (if any)	
Preferred Contact Method	
Is it safe to contact client directly?	
Emergency Contact (Name & Number)	
GP / Primary Healthcare Provider	

Reason for Referral

☐ General Health Check-Up

☐ Sexual Health Check-Up

☐ Psychologist / Talanoa Session

☐ Pacific Rainbow+ Youth Skills Group

☐ Other (please specify): _____

Additional details (symptoms, concerns, or context):

Service Specifics

Urgency of Referral	☐ Routine ☐Within 1 week ☐Immediate
Services Requested	☐ STI Checks ☐ Contraception Advice ☐ Counselling / Psychologist Session ☐ Health Checks ☐ Wellbeing Support ☐ Other: _____
Has the client previously engaged with Village Collective?	☐ Yes ☐ No ☐ Not Sure

Consent & Privacy

☐ I confirm the client has provided consent for this referral.

☐ I understand this information will be kept confidential and used only for the purpose of referral.

Client Signature (if applicable): _____	**Date: ____/____/___**
Referrer Signature (if applicable): _____	**Date: ____/____/___**

For Clinic Use Only *(internal section)*

Date Received: _____
Received By: _____
Action Taken/Notes: _____
Appointment Date: _____