

## Village Collective Clinic – Service Referral Form

### Referrer Information

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

### Client Information

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

### 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

<b>Urgency of Referral</b>	<input type="checkbox"/> Routine <input type="checkbox"/> Within 1 week <input type="checkbox"/> Immediate
<b>Services Requested</b>	<input type="checkbox"/> STI Checks <input type="checkbox"/> Contraception Advice <input type="checkbox"/> Counselling / Psychologist Session <input type="checkbox"/> Health Checks <input type="checkbox"/> Wellbeing Support <input type="checkbox"/> Pacific Rainbow+ Youth Skills Group (Sei Lelei) <input type="checkbox"/> Other: _____
<b>Has the client previously engaged with Village Collective?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
<b>How did you hear about us?</b>	*Dropdown Menu* - Family/Friends - Social Media - Social Media Influencer - Online Advertising - Social Worker or Youth Worker - Mental Health Professional - Doctor / GP - Community Event / Outreach - Physical Advertisement - Other

## Consent & Privacy

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

<b>Client Signature (if applicable):</b> _____	<b>Date:</b> ____/____/____
<b>Referrer Signature (if applicable):</b> _____	<b>Date:</b> ____/____/____

Email complete form to [clinic@villagecollective.nz](mailto:clinic@villagecollective.nz)

**For Clinic Use Only (*internal section*)**

Date Received: \_\_\_\_\_

Received By: \_\_\_\_\_

Action Taken/Notes: \_\_\_\_\_

Appointment Date: \_\_\_\_\_