

Village Collective Clinic – Referring Family member or Friend

Consent

Referred is 16 years old and UNDER	<input type="checkbox"/>	Referred is OVER 16 years of age	<input type="checkbox"/>
By ticking this you confirm that the information provided in this referral form has been shared with the young person's legal guardian(s)	<input type="checkbox"/>	By ticking this you confirm that the information provided in this referral form has been shared with the person	<input type="checkbox"/>

Referrer Information

Name	
Organisation (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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Ethnicity/Cultural Identity	
Preferred Language	
Interpreter Required?	
Address	
Phone Number	
Email Address (if any)	
Preferred Contact Method	<input type="checkbox"/> Phone <input type="checkbox"/> Email Address
Is it safe to contact client directly?	
Emergency Contact (Name & Number & Relationship to Client)	
GP/Primary Healthcare Provider	

Reason for Referral

- General Health Check-Up
- Sexual Health Check-Up
- Psychologist / Talanoa Session
- Pacific Rainbow+ Youth Skills Group
- Peer Support
- Other (please specify): _____

Additional details (symptoms, concerns, or context):

Service Specifics

Urgency of Referral	<input type="checkbox"/> Routine <input type="checkbox"/> Within 1 week <input type="checkbox"/> Immediate
Services Requested	<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: _____
Has the client previously engaged with Village Collective?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
How did you hear about us?	<input type="checkbox"/> Family/Friends <input type="checkbox"/> Social Media <input type="checkbox"/> Social Media Influencer <input type="checkbox"/> Online Advertising <input type="checkbox"/> Social Worker or Youth Worker <input type="checkbox"/> Mental Health Professional <input type="checkbox"/> Doctor / GP <input type="checkbox"/> Community Event / Outreach <input type="checkbox"/> Physical Advertisement <input type="checkbox"/> Other: _____

Confidentiality

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: ___/___/___

Email complete form to clinic@villagecollective.nz

For Clinic Use Only (*internal section*)

Date Received: _____

Received By: _____

Action Taken/Notes: _____

Appointment Date: _____