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**Child Development Team ReferraL**

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| --- |
| Childs Name:  |
| Also Known As:  |
| NHI:  | DOB:  | Sex: [ ]  Male [ ]  Female | Ethnicity: |
| Interpreter required? [ ]  Yes [ ]  No | Language:  | Country of Birth:  |
| If not New Zealand born, please attached proof of New Zealand Residency. |
| Name of Primary Caregiver(s):  |
| Relationship to the child:  |
| Address:  |
|  |
| Mobile:  | Home:  | Work:  |
| Email: |
| Preferred method of contact:  |
| I have discussed this referral with the Primary Caregiver:  | [ ]  Yes | [ ]  No |
| **Why are you referring this child?** |
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| **Are there any other services involved with this child/ family now or in the past?** |
| [ ]  Infant, Child Adolescent & Family Mental Health Service (iCAMHS) |
| [ ]  Ministry of Education Learning Support |
| [ ]  Support Net / NASC |
| [ ]  Well Child Provider e.g. Plunket, Tipu Ora |
| [ ]  Hospital-based services |
| [ ]  Oranga Tamariki - Child Youth & Family |
| [ ]  ACC |
| [ ]  Child and family community-based services |
| [ ]  Other (please specify):  |
| **Please attach other relevant information:** |
| E.g. current problems, social and family issues, developmental history, past medical history and medication, school information, include any relevant reports. |
| Referred By:  |
| Title/ Agency:  |
| Address:  |
| Phone:  | Fax:  |
| Email:  |
| Signature:  | Date:  |

**Please return to:**

Attention: Child Development Team

**E:** outpatient1.referrals@lakesdhb.govt.nz

**F:** 07 349 7994

**M:** Referral Centre, Rotorua Hospital, Private Bag 3023, Rotorua Mail Centre, Rotorua 3046

*“Incomplete referrals may be returned to Referrer.”*