**Ko Wai Au Referral form**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | | | | |
| D.O.B: |  | | Age: | |  |
| Gender: | Female Male Other | | | | |
| Address: |  | | | | |
| Ethnicity: |  | | | | |
| Phone number # | Home: | | Mobile: | | |
| Is the rangatahi already engaged with services:  (If yes please provide details of service providers) | | | | | |
| Reason for referral (brief description): | | | | | |
| Additional information: | | | | | |
| Name and contact number of referrer: | | Agency: | | Date and Time of referral: | |

ONCE COMPLETED PLEASE SEND TO – [kiaora@kowaiau.co.nz](mailto:kiaora@kowaiau.co.nz)