

Referral/Intake Form

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| Referral Source: | | Date: | |
| Full Name: | | Referrer's Role: | |
| Phone: | | Region/City: | |
| Email: | | | |

Client Details

| | | | |
|---|--|------------|--|
| First Name: | | Last Name: | |
| Date of Birth: | | Address: | |
| Mobile: | | Ethnicity: | |
| Email: | | | |
| Immigration Status: | | Religion: | |
| <input type="checkbox"/> Refugee Status | <input type="checkbox"/> Interpreter required* | *Language: | |

**In "Extra notes", include children's names & DOB and language of interpreter required*

Reason for Referral

(Please provide a brief description of why the client is being referred.)

Additional Information

- Are there any risks or issues we should know about? (e.g., mental health, substance use, legal)?
☐ Yes ☐ No
If yes, please specify: _____
- Has the client been involved in any programs before?
☐ Yes ☐ No
If yes, please specify: _____

- Is the client working with any other agencies/organisations?
- Any other relevant information:

Referral Source Consent

I confirm that the client has consented to this referral and the sharing of their information.

☐ Yes ☐ No

Instructions for Submission

Please submit this form via:

- ☐ Email: navigator@shama.org.nz
- ☐ In-person: 27 Beatty Street, Melville, Hamilton 3206

For questions, contact: 022 422 4550

Office Use Only:

Shama Staff:

Referral Pick-Up Date: