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| REFERRAL FORM***Whānau Mai - Antenatal Education*** |
| **Whānau Details** | **Referral Date:** |   |   |   |   |
| **First Name:** |   | **Whānau Name:** |   |
|   |  |   |
| **AGE/DOB:** | **NHI:** | **Ethnicity:**  |   |
|   |  |   |   | **Mama/Hapu/Iwi:****Pepe/Hapu/Iwi:** |   |
|  |  |  |  | **Parity – P / M:** |  |
| **Gender: ** | Male  |  | Female | **Due Date:** |   |   |   |   |   |   |
|  |   |   |   |   |   |   |
| **Contact Details** |   |   |   |   |   |   |
| Home Phone: |   | Mobile: |   | Email: |
| Address: |   |   |   |   |   |
| Suburb: |   | Town: **If Remote/Rural** - Area Code: |
|  |   |   |   |   |   |   |
| **# and Name of Supporting Whanau to attend and relationship** |
|   |
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|   |
|   |
| **Referrer:** |  |  | **Service/Agency:** |  |  | **Contact Phone:** |  |  |  |
|   |   |   |
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| **Referrals can be emailed to:**  |  |  |  |  | Te Puawaitanga Ki Ōtautahi Trust |  |
| Reception@omwwl.maori.nz |  |  |  |  |  | P.O. Box 16886, Hornby,  |  |  |
| **0800 66 99 57 or 03 344 5062**Fax: 03 349 0645 |  |  |  |  |  |  | Christchurch |  |  |  |