Manawa Ora
Healthy Heart Healthy Homes
Ngā Whare Hauora

Health New Zealand
Te Whatu Ora

Manawa Ora Referral Form

Client's name: _____

Client's NHI: _____ DOB: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Client's ethnicity: NZ Māori: ☐ NZ European: ☐ Pasifika: ☐ Other: ☐ _____

Client Iwi: _____ Client Hapū: _____

Pacific Nation: _____

(If child under 19 please fill out guardian information below)

Guardian's full name: _____ Relationship to Child: _____

Phone: _____ Alternate phone: _____

Email: _____

Eligibility criteria – must meet the following three criteria (please tick):

(a) Live in the Northland DHB catchment area (from Te Hana in the south to Cape Reinga): ☐

(b) Residency status: New Zealand citizen: ☐ New Zealand permanent resident: ☐

(c) The parents/caregivers/family have a Community Services Card (CSC) or are eligible for one: ☐

In addition, belong to one of the following groups (please tick):

Group 1

- Is the client **aged 0- 5 years old** and hospitalised within the last 12 months – *or is at risk of hospitalisation due to their housing conditions* – with one of the following
- indicator conditions: LRTI, pneumonia, bronchiectasis, bronchiolitis, meningitis, TB, GAS sepsis, meningococcal disease, positive strep GN, Rheumatic Fever? ☐

Group 2

- Does the family have a child **aged 0-5 yrs** with at least two of the following social risks: finding of neglect or abuse by Oranga Tamariki, caregiver of child have a corrections history, long term benefit recipient, or mother has no formal qualifications. ☐

Group 3

- Hapū māmā (pregnant), or has a baby 0- 12 months of age. ☐

Manawa Ora
Healthy Heart Healthy Homes
Ngā Whare Hauora

Health New Zealand
Te Whatu Ora

Group 4

- Is the client receiving monthly Bicillin Injections for Rheumatic Fever? ☐
- Is the client aged **under 19 years of age** and are hospitalised within the last 12 months with one of the following indicator conditions: *(LRTI, pneumonia, bronchiectasis, bronchiolitis, meningitis, TB, GAS sepsis, meningococcal disease, positive strep GN, Rheumatic Fever)?* ☐
- Has there been 3 positive Strep A results from the household in *any* three month period? ☐
- Number of occupants in the home as identified by the whanau _____

Comments:

Property status – Tick one			
Own home		Kāinga Ora home	
Live in a whānau owned home		Private rental	
Other			

Referrer details

Referrer's name: _____

Phone number: _____ Email: _____

Organisation: _____

Date of referral: _____

☐ I would like to discuss this referral with Manawa Ora.
☐ I would like to be informed of the outcome of this referral.

Manawa Ora
Healthy Heart Healthy Homes
Ngā Whare Hauora

Health New Zealand
Te Whatu Ora

Informed consent

I / We give informed consent for the following (tick):

- ☐ **I am happy to be referred to the Manawa Ora Programme to see if there are any services that will help to improve my housing situation.**
- ☐ **I consent to my data which could include photo's being de identified and used for research and evaluation of the Healthy Homes and Well homes initiatives.**
- ☐ **I am happy for the Manawa Ora service and their contracted providers to share my information with any other agencies that can help improve my housing conditions.**
- ☐ **I am happy for Manawa Ora to access my child's medical records if necessary, to check if they are eligible for services which may improve our health and housing conditions.**

Name: _____ *Date:* _____

Signature: _____

If you are unsure whether a family is eligible or not, please complete a referral form, and the Manawa Ora team will contact you for further information if required.

Email: manawaora@Northlanddhb.org.nz Phone: 0800 155 173