

Community Health 4 Kids
Freephone: 0800 935 554

REFERRAL Public Health Nurse (PHN) Service Community Health 4 Kids (CH4K)

Please tick who referral is for:

☐ PHN ☐ PHN (early years) ☐ Ear Nurse ☐ VHT

Child's Surname (s) _____ First Name(s) _____

DOB: _____ Gender: _____ NHI: _____ Ethnicity: _____

Address: _____

Parent/Caregivers _____

Contact number(s) Home: _____ Mobile: _____

Email address: _____

Has referral been discussed with caregiver? ☒ Yes ☐ No

If No state why _____

Has CH4K service leaflet been provided to caregiver? ☐ Yes ☒ No

Has the caregiver agreed to the referral? ☒ Yes ☐ No

School/Preschool _____ Classroom _____

Referrer name _____ Agency _____

Referrers contact (number and email) _____

Date of referral _____

Are you aware if child /family are engaged with other services (please tick)

GP	RTL	SENCo	3D-CHIRP	Paediatrics	MiCAMHS	Voyagers
Counselling	Family works	SWIS	Strengthening Families	CDS	CDU	
Oranga Tamariki	Tamariki Ora/ Well child	STAND	Plunket	Family Start		
Adult MH	Kāhui Ako	MoE	OTHER (please state)			

Reason for referral and other relevant information

Expected outcomes of referral to CH4K

Date referral received by PHN _____