

REFERRAL / APPLICATION

HORIZONS
Te Whiti O Te Ra
PO Box 52075
Titahi Bay
Ph. 236-6761

A service of Wellington After-Care Association

Note: This application form is to be filled out in consultation with the applicant. It remains confidential to the applicant, the referring agency and the staff of Wellington After-Care Association Inc.

Date of Referral :

Centre :

Name :

Date of Birth :

Address :

Age :

Phone No :

Male/Female

Primary Contact Person :

Phone No :

NZ Maori

N.Z. European or Pakeha

Other European →

Samoan

Cook Island Maori

Tongan

Niuean

Chinese

Other (Such as Fijian, Korean)

Which of these groups?

English

Dutch

Australian

Scottish

Irish

Other

↓
←
If "Other" please print your ethnic groups

Referred by:

Agency\Individual

Please Turn Over ↷

Reason for Application:

What do you hope to gain by attending:

Diagnosis/Present Difficulties:

Relapse Indicators: (It would be helpful for us to know any signs you notice if you're becoming unwell)

Who would you like us to contact if you become unwell?

Name: _____

Phone: _____

Please return this form to: Horizons, P.O. Box 52075, Titahi Bay