



LIFESTYLE SUPPORT SERVICES DATABASE

Please provide at least one valid contact number/email and attach any relevant information you would like included.

- Add entry
 Change current entry
 Delete entry

Organisation Title: _____

- NGO
 Trust
 Māori Provider
 Govt. Org
 Other: _____

Main Contact: _____	Designation: _____
Physical Address: _____	Postal Address: _____
_____	_____
Town/City: _____	Town/City: _____
Phone: _____	Postcode: _____
Phone 2: _____	Fax: _____
Mobile: _____	Email: _____
Website: _____	Email 2: _____
Service Areas: _____	_____

SERVICE CATEGORIES APPLICABLE TO YOUR ORGANISATION: (Choose all that Apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Child | <input type="checkbox"/> Family | <input type="checkbox"/> Sleep | <input type="checkbox"/> Substance Use |
| <input type="checkbox"/> Men's Health | <input type="checkbox"/> Stress | <input type="checkbox"/> General Practice | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Women's Health | <input type="checkbox"/> Healthy Weight | <input type="checkbox"/> Cultural Support | <input type="checkbox"/> Physical Activity |
| <input type="checkbox"/> Older Peoples Health | <input type="checkbox"/> Employment | <input type="checkbox"/> Māori Health Provider | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Advocacy | <input type="checkbox"/> Relationships | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Finances | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Transport |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Social | <input type="checkbox"/> Home Help | <input type="checkbox"/> Oral Health |
| <input type="checkbox"/> Blindness/Sight | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Disability Support | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hearing | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | <input type="checkbox"/> Youth Health | |
| <input type="checkbox"/> Other (please state) _____ | | | |
| <input type="checkbox"/> Condition Specific (please specify) _____ | | | |

Fee Information:

- GP
 Nurse
 Other health provider
 Self

Referral Type:

Other (please specify) _____

Referral Form Available?

- Yes
 No
 Attached to form
 Sent via email

Services Provided:

(Please limit to no more than 25 words if possible)

I hereby give consent for info to be included in online and print editions of the Support Services Directory.

Please add my details to your mailing list for the purpose of sending my organisation health related information YES

NO