Nunkuwarrin Yunti
of South Australia Inc.

Approval Date	15/11/2023	Review Date	25/09/2024
Responsible Manager	Manager QSR		

Culture Care Connect Prevention and Aftercare Referral Form

Please FAX completed Form to: Attention to **CCC** (08) 8359 2414
Or EMAIL the completed Form to: ccc@nunku.org.au
If you are emailing this form, please use an encrypted email system to protect the client's privacy.

The following criteria are required for referral to Nunkuwarrin Yunti:
☐ The person is presenting with suicidal thoughts and/or behaviours and distress
☐ The person is a family member/friend/carer of an individual with suicidal thoughts and/or/behaviours
☐ The person is 15 years or older

Consent: The person being referred must consent to this referral			
I have discussed the TALK SUICIDE Support Service referral with the person being referred, and they consent to this referral. They understand that this may include contacting me (the referrer) for further information.			
Signature of referrer:		**Date:**	

Personal Details:						
Surname:						
Given Name(s):				Sex:	☐ Male	☐ Female
Pro-nouns:	☐ Male	☐ Female	☐ Non-Binary	☐ Prefer to Self-Describe	☐ Prefer not to say	
Date of Birth:						
Address:						
Suburb:				Postcode:		
Contact Number:				Ok to Leave Msg?	☐ Yes	☐ No
Email:						
Preferred Language:			Interpreter Required:		☐ Yes ☐ No	
My Origin Is:	☐ Aboriginal ☐ Torres Strait Islander ☐ Unknown					

Next of Kin			
IF THE CLIENT IS AGED UNDER 18, PLEASE COMPLETE BELOW			
I consent to Nunkuwarrin Yunti contacting my next of kin in an emergency			☐ Yes ☐ No
Next of Kin Name:		Contact No:	
Relationship with Client:	☐ Parent ☐ Partner ☐ Child ☐ Other Relative ☐ Friend		

Referrer Details:		
Name:		
Organisation/Department:		
Phone Number:		
Is the individual engaged with your service:	☐ Yes ☐ No	

Client Contact Information
PLEASE SELECT WHAT THE SUPPORT THE CLIENT REQUIRES
☐ Prevention ☐ Aftercare ☐ Intervention ☐ Postvention

Information about the incident			
Incident Location:		Date of Incident:	
Incident Type:	☐ Attempted Suicide		
	☐ Other trauma involving death		
	☐ Other trauma not involving death		
Incident Cause/Method:	Please provide brief description below		

Other relevant information: e.g. does the person have any other support network? Are there any risks involved i.e. history of violence

Assessed level of risk *(please include any documentation/notes) including any current medications or presenting concerns which may add to risk*

Identified Client Needs
PLEASE SELECT WHAT THE SUPPORT THE CLIENT REQUIRES
Is there anyone you are particularly worried about?
How many people live at your house?
Will you be having extra family come stay for sorry business?
What is your preferred way/time to be contacted?