Nunkuwarrin Yunti
of South Australia Inc.

Approval Date	28/02/2023	Review Date	28/02/2028
Responsible Manager	General Manager Clinical Services		

Nunkuwarrin Yunti Family Partnership Program External Referral Form

Please FAX completed Form to: Attention to ***NYFPP*** (08) 8250 1864

Or EMAIL the completed Form to: nyfpp@nunku.org.au

If you are emailing this form, please use an encrypted email system to protect the client's privacy.

CLIENT DETAILS			
Given Name(s):	______________________	**Family Name:**	______________________
Preferred Name(s): **If different from given name**	______________________	**Date of Birth:**	_____/ _____/ _____
Please Select:	**Aboriginal** **Torres Strait Islander**	**Non-Aboriginal member of an Aboriginal family**	
Address:	______________________		
Telephone (Home)	______________________	**Telephone (Mobile)**	______________________
Email:	______________________		
REFERRER			
Referrer Name:	______________________	**Organisation:**	______________________
Position/Role:	______________________	**Date of Referral:**	_____/ _____/ _____
Phone Contact:	______________________	**Fax Number:**	______________________
Email:	______________________		
Has the client consented to this referral?	YES NO If NO you need to seek and receive consent prior to referring.		
PLEASE LIST ANY OTHER SERVICES THAT THE CLIENT IS LINKED WITH:(i.e. DCP, NDIS)			
Name of Service(s)		Contact Details (If Known)	
______________________		______________________	
______________________		______________________	
______________________		______________________	
______________________		______________________	

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

REFERRAL INFORMATION

Eligibility Criteria

Pregnant Aboriginal or Torres Strait Islander woman **OR** Having an Aboriginal or Torres Strait Islander baby	Yes	No
First time mother and/or first opportunity to parent	Yes	No
Under 26 weeks pregnant	Yes	No
Living in Metropolitan Adelaide for the duration of the program:	Yes	No

Client Information

Is client receiving antenatal care? Yes No

If yes, where: ______________________________

Estimated due date: _____/ _____/ _______

Previous pregnancy outcomes:

Partner's Name: ______________________________ Is the father of the baby: Yes No Unknown

Other relevant information/history/risk factors/special needs:

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NUNKUWARRIN YUNTI ADMINISTRATION USE ONLY

Date referral received:	_____/ _____/ _______	Received by:	
Date referral allocated:	_____/ _____/ _______	Allocated to:	
Date scanned into Communicare:	_____/ _____/ _______	ID#:	
Outcome of Referral:	Accepted Not Accepted	Referral Agency Notified:	Yes No
Home Visitors Allocation:	Nurse:	Family Partnership Worker:	