Nunkuwarrin Yunti of South Australia Inc.

Approval Date	14/11/2024	Review Date	14/11/2025
Responsible Manager	General Manager Culture and Community Safety		

Strong Families, Strong Communities
External Referral Form

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

FAMILY DETAILS

Family Name _____

Address _____

Suburb _____ **Postcode** _____

Telephone (Home) _____ **Telephone** _____

Email: _____

Preferred Language: _____ **Interpreter Required?:** ☐ Yes ☐ No

Name(s) of child: _____ **Date of Birth:** ____ / ____ / ____

Sex ☐ Male ☐ Female **Pronouns:** ☐ He/Him ☐ She / Her ☐ They / Them ☐ Prefer to self-describe ☐ Prefer not to say

Please select: ☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Aboriginal & member of an Aboriginal Family

Name(s) of child: _____ **Date of Birth:** ____ / ____ / ____

Sex ☐ Male ☐ Female **Pronouns:** ☐ He/Him ☐ She / Her ☐ They / Them ☐ Prefer to self-describe ☐ Prefer not to say

Please select: ☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Aboriginal & member of an Aboriginal Family

Name(s) of child: **Date of Birth:** ____ / ____ / ____

Sex ☐ Male ☐ Female **Pronouns:** ☐ He/Him ☐ She / Her ☐ They / Them ☐ Prefer to self-describe ☐ Prefer not to say

Please select: ☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Aboriginal & member of an Aboriginal Family

IF THE CHILD IS AGED UNDER 17, PLEASE COMPLETE BELOW

I consent to Nunkuwarrin Yunti contacting my next of kin in an emergency

Next of Kin Name: _____ Contact No: _____

Relationship with Client: ☐ Parent ☐ Partner ☐ Child ☐ Other Relative ☐ Friend

Client's signature _____ **Date:** ____ / ____ / ____

The following criteria are required for referral to Stronger Families, Stronger Communities at Nunkuwarrin Yunti:

☐ The child or family members are aged between pre- birth to 17 years

☐ The person that requires the service/support is a family member/friend/carer of an Aboriginal and or Torres Strait Islander person to support families who are likely to have contact with the child protection system. The program will address the needs of children, young people, and families to:

- Enable children to remain safely with their families.
- Have the ability to improve family safety and wellbeing.
- Have the ability to build and sustain family functioning.

Increase service navigation, access, and advocacy support.

REFERRER

I have discussed the referral with the family being referred, and they consent to this referral. They understand that this may include sending unidentified data to a Government department - Department of Human services, to improve services for Aboriginal and Torres Strait Islander people.

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 receive consent prior to referring.

Referrer's signature

_____

REFERRAL INFORMATION

Referral Type: ☐ Self-Referral ☐ Family/Carer ☐ Worker

Please tell us a little bit about your reason for this referral:

PLEASE STATE WHAT THE SUPPORT THE CHILD/ FAMILY REQUIRES- after 1st appointment what services are required?

Other relevant information: e.g. does the child have any other support network? Are there any risks involved i.e. history of family based violence, Alcohol and or drug related considerations, Mental health issues, Physical health issues, Housing stress

ASSESSED LEVEL OF RISK (PLEASE INCLUDE ANY DOCUMENTATION/NOTES) AND COMPLETE FAMILY AND CHILD SAFETY PLAN

Identified Child and Family Needs

PLEASE STATE WHAT THE SUPPORT THE FAMILY REQUIRES

Is there anyone you are particularly worried about?

How many people live at your house?

PLEASE LIST ANY OTHER SERVICES THAT THE CLIENT IS LINKED WITH:(i.e. DCP, NDIS)

Name of Service	**Contact Details (If known)**

NUNKUWARRIN YUNTI ADMINISTRATION USE ONLY			
Date referral received:	____ / ____ / _____	Received by:	
Date referral allocated:	____ / ____ / _____	Allocated to:	
Date scanned into Communicare:	____ / ____ / _____	ID#:	