Nunkuwarrin Yunti of South Australia Inc.

Approval Date	28/02/2023	Review Date	28/02/2028
Responsible Manager	Executive Manager Culture & Community Safety		

TP (Social and Emotional Wellbeing) External Referral Form

Please FAX completed Form to: Attention to **TP** (08) 8359 2414

Or EMAIL the completed Form to: tp@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.

REFERRAL INFORMATION

Would the client prefer: ☐ Male ☐ Female ☐ Either

Will the client require: ☐ Short Term Support (0 – 6months) OR ☐ Long Term Support (longer than 6months)

Name of the community to whom client is known and connected (if known):

Reason for referral: Please include current supports in place by referring agency

_____

_____

_____

_____

_____

Physical health concerns (does client access NY GP service? Or have access an external GP)

Mental health concerns (i.e., does the client need a Mental Health Care Plan or already have one?)

RISK MANAGEMENT:

(Any Known Risks that worker should be aware of? i.e., Barriers to Home visiting etc)

ANY OTHER RELEVANT INFORMATION AS IDENTIFIED BY REFERRER:

(Please include the details of any other services involved with this client or other identified issues i.e. criminal justice matter, risk of homelessness, job network, Centrelink status)

Do you require feedback on this referral? ☐ **Yes** ☐ **No**

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#:	