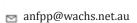


ABN 21 471 474 869 166 Brisbane St Dubbo, NSW 2830











## **Service Provider Referral Form**

ELIGIBILITY				
Pregnant Aboriginal and/or Torres Strait Islander woman OR Having an Aboriginal and/or Torres Strait Islander baby? Less than 26 weeks Pregnant First time mother or first opportunity to parent? Living within Wellington, Dubbo, Gilgandra or Narromine Areas				
REFERRER'S DETAI	LS			
Date of Referral:				
Referring Agency:	Referring Person:			
Email:	Ph:			
Address:				
CLIENT DETAILS				
Name:	DOB:			
Address:				
Phone:	Phone: Best time to contact:			
Medicare Number:	Ref No.: Expiry Date:			
Gestation (weeks):	/40 Due Date:			
General Practitioner (GP):				
Client is:	Aware of referral Unaware of referral			
	Aboriginal or Torres Strait Islander Neither			
	Confirmation of Aboriginality (COA)			
Father is:	Aware of referral Unaware of referral			
	Aboriginal or Torres Strait Islander  Confirmation of Aboriginality (COA)			
	Confirmation of Aboriginality (COA)			
SUPPORT PERSON				
Name:	Ph:			
Address:				
Relationship to Client:				

CLIENT INFORMATION			
Are the family aware of the pregnancy?	Yes	No	
Has the client experienced any of the following:			
Mental health problems Dru	ug and alcohol misuse	Domestic Violence	
AVO in place Safe	ety concerns		
Are there any other significant risk factors that you are aware of or services working with the client?			
Please note home visits will only take place following satisfactory safety assessment.			
Please ensure as much information as possible is entered, to enable referral to be processed as quickly as possible and to assist in assessing whether to offer the client a place on the Program. Failure to do so could delay the client the opportunity to access this service. Attach additional information as needed.			
Additional Informaton is attached.			
Contact 02 5816 9010   Email anfpp@wachs.net.au			
OFFICE USE			
Referral has been: Accepted	Declined		
NHV:	AFPW:		
Team Leader/ Nurse Supervisor:		Date:	