Western Sydney Nepean Blue Mountains

Greater Western Aboriginal Health Service

GWAHS ANFPP Building
23 Luxford Rd, Mt Druitt
02 8869 4100
anfpp@gwahs.net.au

Australian Nurse-Family Partnership Program

Nurse-Family Partnership
Helping First-Time Parents Succeed®

Growing Stronger Families
Funded by the Australian Government

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 the Blacktown or Nepean Local Government Area

REFERRER'S DETAILS

Date of Referral:

Referring Agency: Referring Person:

Email: Ph:

Address:

CLIENT DETAILS

Name: DOB:

Address:

Phone: Best time to contact:

Email:

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

Father is:
- ☐ Aware of referral
- ☐ Unaware of referral
- ☐ Aboriginal or Torres Strait Islander
- ☐ Neither

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 ☐ Drug and alcohol misuse ☐ Domestic Violence

☐ AVO in place ☐ Safety 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.

Please email: anfpp@gwahs.net.au

OFFICE USE

Referral has been: ☐ Accepted ☐ Declined

NHV: AFPW:

Team Leader/ Nurse Supervisor: Date: