IUIH Family Partnership Program
Referral Form

Northside - Ph: (07) 3481 9700 or 1800 802 265 | Fax: (07) 3205 8666 | Email: anfpp@iuih.org.au
Southside - Ph: (07) 3437 8975 or 1800 802 265 | Email: anfpp@iuih.org.au

CLIENT LABEL/DETAILS

Given Name/s: ______________________________

Surname: ______________________________

Address: ______________________________

Email: ______________________________

Telephone No: ______________________________

Client consents to be contacted by:

Telephone   Email

Client DOB: __________ Client EDC: __________

Current Gestation: _____/40 weeks

Previous pregnancy outcomes:

____

REFERRAL CRITERIA

The IUIH Family Partnership Program could be right for your client if they are:

- A pregnant Aboriginal or Torres Strait Islander woman, or having an Aboriginal or Torres Strait Islander baby
- First Opportunity to Parent
- Under 26 weeks pregnant
- Living in the North Brisbane/Caboolture area
- Living in the Brisbane South, Redlands, Logan or Ipswich area

REFERRING AGENCY (if applicable)

Referring agency: ______________________________

Contact person: ______________________________

Telephone: ______________________________

Email: ______________________________

Date of Referral: ______________________________

Client Cultural background

Aboriginal   Torres Strait Islander   Both

Other (please specify) ______________________________

Father of Baby Cultural background

Aboriginal   Torres Strait Islander   Both

Other (please specify) ______________________________

Partner/NOK/Support Person

Given name/s: ______________________________ Surname: ______________________________

Address: ______________________________

Telephone: ______________________________ Relationship: ______________________________

ADDITIONAL INFORMATION (ie: strengths/past history, risks, supports, complexities)

OTHER SERVICE PROVIDERS (please list names & numbers)

IUIH USE ONLY

Date referral outcome: ______________________________ *Consent provided:*   *Yes*   *No*

IUIH ANFPP Client ID: ______________________________ *ANKA Alias:* ______________________________

Outcome of referral:

Accepted   *Declined*   *Unable to contact*   *Not eligible*   *Program place full*

ANFPP REFERRAL FORM_2_OCT18