# Australian Family Partnership Program

## Referral Form

afpp@iuih.org.au iuih.org.au/afpp

**Date of referral:** _____

### CLIENT LABEL / DETAILS

Given name/s: _____

Surname: _____

Address: _____

Telephone No: _____

Client consents to be contacted by:

☐ Telephone ☐ Email

Client DOB: _____ Due date: _____

Current Gestation: _____ /40weeks

Previous pregnancy outcomes:

_____

### Referring agency (if applicable)

Referring agency: _____

Contact person: _____

Telephone: _____

Email: _____

### Partner/NOK/Support Person

Given Name/s: _____ Surname: _____

Address: _____

Telephone No: _____ Relationship: _____

### Referral criteria

The AFPP could be suitable for you
(if you are referring yourself) OR your client.
To be eligible they need to meet the following criteria:

☐ A pregnant woman birthing an Aboriginal or Torres Strait Islander baby

☐ First time mother or having the first opportunity to parent*

☐ Under 28 weeks pregnant or more than 28 weeks pregnant may be considered on a case-by-case basis

☐ Living in the North Brisbane/Caboolture region OR

☐ Living in the Brisbane South, Redlands, Logan or Ipswich region

### Client cultural background

◯ Aboriginal ◯ Torres Strait Islander ◯ Both

◯ Others(please specify): _____

### Father of baby cultural background

◯ Aboriginal ◯ Torres Strait Islander ◯ Both

◯ Others(please specify): _____

### Additional information (ie: strengths/past history, risks, supports, complexities)

Are the family aware of the pregnancy? ☐ Yes ☐ No

Has the client experienced any of the following:

☐ Mental health problems
☐ Drug or alcohol misuse
☐ Domestic violence (current or history of)
☐ AVO in place
☐ Safety concerns
☐ Homeless/transient housing
☐ Isolation/lack of support

*Women who have experienced a neonatal death, have had a child removed from their care immediately after birth, or had their first baby adopted immediately after birth.

### Other service providers (please list names & numbers)

### IUIH use only

Date referral outcome:

IUIH AFPP Client ID:

Outcome of referral:

Consent provided: ☐ Yes ☐ No

ANKA Alias:

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