



District: \_\_\_\_\_  
FF #: \_\_\_\_\_  
Map Grid: \_\_\_\_\_  
Clerk's Initials: \_\_\_\_\_  
New: \_\_\_\_\_  
Active Unit: \_\_\_\_\_  
Inactive: \_\_\_\_\_

## REFERRAL FORM

Date of Referral: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Referring Source: \_\_\_\_\_ ( ) ( )  
Agency Contact Person Phone # Fax #

Send Reports To: \_\_\_\_\_

Client Name: \_\_\_\_\_ Sex: M  F  Hospital Record: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First Mother's Maiden Name

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First

Address: \_\_\_\_\_  
Street Apt # City Zip  
( ) ( ) ( )  
Home Phone Work Phone Alternate Number

Language Spoken:  English  Spanish  Vietnamese  Other \_\_\_\_\_

### REASON FOR REFERRAL

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Mother/Infant Bonding Issues             | <input type="checkbox"/> Failure to Thrive                           | <input type="checkbox"/> History/Current Depression PPD               |
| <input type="checkbox"/> Breastfeeding Concerns                   | <input type="checkbox"/> Drug Withdrawal                             | <input type="checkbox"/> Teen Mom                                     |
| <input type="checkbox"/> Feeding Problems Impacting Infant Health | <input type="checkbox"/> Asthma                                      | <input type="checkbox"/> Immunization F/U                             |
|   | <input type="checkbox"/> Cesarean Delivery with Complications        | <input type="checkbox"/> History Drug Use                             |
|   | <input type="checkbox"/> Diabetes                                    | <input type="checkbox"/> History/Current Emotional/<br>Physical Abuse |
|   | <input type="checkbox"/> Premature: GA at Delivery _____             |   |
|   | <input type="checkbox"/> Obesity                                     |   |
|   | <input type="checkbox"/> Complications/Birth Defects? Specify: _____ |   |

### COMPLICATING FACTORS

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Insurance Assistance | <input type="checkbox"/> Poor Living Conditions | <input type="checkbox"/> Low Literacy            | <input type="checkbox"/> No Literacy            | <input type="checkbox"/> First-time Mom |
| <input type="checkbox"/> Poor Support         | <input type="checkbox"/> Medical Home F/U       | <input type="checkbox"/> Health/Parent Education | <input type="checkbox"/> Very Limited Resources |   |
- Pediatrician &/or OB/GYN Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Infant Stat: BW \_\_\_\_\_ L \_\_\_\_\_ HC \_\_\_\_\_ Apgar \_\_\_\_\_

Children/Teens: HT \_\_\_\_\_ WT \_\_\_\_\_ BMI \_\_\_\_\_

Prenatal Care: Yes  No  Where \_\_\_\_\_ Parity \_\_\_\_\_ Gravida \_\_\_\_\_ EDC \_\_\_\_\_

Note reason(s) based on indicators (outlined in 2006 Priority Guidelines) for PHN visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other referrals to: \_\_\_\_\_