

Date: _____

Healthy Start Referral and Assessment Form

Case Manager Assigned:
Date:
Initial:

General Information

Name:		Date of Birth:	
Physical Address:			
Mailing Address (if different from above):			
City:		State, Zip:	
Home Phone:		Cell Phone:	
Alternate Contact Person:		Alternate Phone:	

Pregnancy Information

Is Referral Pregnant? (If No, skip to next section)			<input type="checkbox"/> Yes	<input type="checkbox"/> No
First Time Parent?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weeks Gestation:		Due Date:		
Pre-Existing Medical Conditions? Please List.				
Medicaid Eligible?	<input type="checkbox"/> Pending	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Health Care Provider:

Family Information

Does Referral Have Other Children?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, List Ages of Children:				

Initial Referral Assessment:

History of depression/mental illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of domestic violence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of drug and/or alcohol abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of smoking or current smoker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experiencing grief from a loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Referral Source Information:

Agency/ Organization:	
Name:	Title:
Phone Number:	Fax Number:

Additional Notes:

I allow for an exchange of information between the above named Referral Source and The Family Tree Healthy Start Program, the Office of Public Health's Nurse Family Partnership Program, United Way Early Head Start Program, _____ (Other Referral Source) for the purposes of follow-up regarding my participation status with the mentioned agencies. Fax to 337-295-7024

Referral Signature

Date

Referral Source Signature

Date

For Office Use Only:		Outreach Initials:	
<input type="checkbox"/> Mailing List	<input type="checkbox"/> Healthy Start Connection		<input type="checkbox"/> Health Education Classes
<i>Community Programs Eligibility:</i>			
Nurse Family Partnership: <input type="checkbox"/> Yes <input type="checkbox"/> No	Consent to refer to NFP: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Early Head Start: <input type="checkbox"/> Yes <input type="checkbox"/> No	Consent to refer to EHS: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Disposition of Referral
<input type="checkbox"/> Enrolled
<input type="checkbox"/> Unsure
<input type="checkbox"/> Refused services
<input type="checkbox"/> Referred to another agency
Date Referred: _____
HS Staff Initial: _____