

THE FAMILY TREE

INFORMATION, EDUCATION & COUNSELING CENTER



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Healthy Start Referral Form

Attn: Jerri Byrd Hodges
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Parishes Served:

Acadia
Evangeline
Iberia
Lafayette
St. Landry
St. Martin
Vermillion

Date of Referral: _____ / _____ / _____

Personal Information (please print):

Participant Name: _____
(Last Name) (First Name) (Maiden, if applicable)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: Cell Home _____ Email Address: _____

Alternative Contact Person: _____ and Phone Number: _____

Date of Birth: _____ / _____ / _____ Age: _____

Race: White Black or African-American American Indian or Alaskan Native Asian Native Hawaiian or
Other Pacific Islander Hispanic or Latino (of any race) Other _____

Marital Status: Married Divorced Single Widowed Separated Remarried

Pregnancy Information (please print):

Is Referral Pregnant? Yes No # Weeks Gestation: _____ Due Date: _____ / _____ / _____

First Time Pregnancy? Yes No List Ages of Other Children: _____

List any pre-existing medical conditions: _____

Medicaid Eligible? Yes No Healthcare Provider (OB/GYN): _____

Initial Referral Assessment (please print):

History of Depression/Mental Health? _____

History of Domestic Violence? _____

History of Alcohol/Drug Abuse? _____

History of Smoking or Current Smoker? _____

History of Negative Birth Outcomes? _____

Referral Source Information (please print):

Agency/Organization Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Title: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

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Healthy Start Referral Response FOR OFFICE USE ONLY

Name of Referral: _____

Date Referral Rec'd: _____ Date Assigned to CM: _____

Case Manager Assigned: _____

Attempts to Contact:

Date/Time: _____ Type of Contact: _____ Result: _____

Date/Time: _____ Type of Contact: _____ Result: _____

Date/Time: _____ Type of Contact: _____ Result: _____

Date/Time: _____ Type of Contact: _____ Result: _____

Date/Time: _____ Type of Contact: _____ Result: _____

Date/Time: _____ Type of Contact: _____ Result: _____

Final Disposition (please circle):

- 1 Enrolled, Healthy Start Program Participant
- 2 Assigned to Case Manager – Pending
- 3 Community Participant – Eligible for Services
- 4 Community Participant – Ineligible for Service
- 5 Referred to OPH-NFP
- 6 Ineligible for Services - Mother not pregnant/Interconceptional > 2 years
- 7 Ineligible for Services – Lives out of project area
- 8 Refused Participation
- 9 Referred to Other Program/Service (Specify): _____
- 10 Unable to Contact
- 11 Follow-up letter Sent (mm/dd/yy): _____
- 12 Previously Referred to HS (mm/dd/yy): _____
- 13 Provided Health Education, Did not Enroll:
- 14 Unable to Provide Service (HS Program Full)

Healthy Start Staff Member Signature

Position

Date