## Personal Information (please print):

|  |  |  |
| --- | --- | --- |
| Date of Referral:  | /\_\_\_\_\_  | / \_\_\_\_\_\_\_\_ |

Participant Name:

# Healthy Start Referral Form

Phone: 318-725-4220

cenlahealthystart@acadianafamilytree.org

**Parishes Served:**

Avoyelles

Catahoula

Concordia

Grant

LaSalle

Rapides

Vernon

Winn

(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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**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