THE FAMILY TREE

INFORMATION, EDUCATION & COUNSELING CENTER

Healthy Start Referral Form

Phone: 337.981.2180 Fax: 337.981.2391
healthystart@acadianafamilytree.org

Parishes Served:
Acadia
Evangeline
Iberia
Lafayette
St. Landry
St. Martin
Vermilion

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