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