

# Healthy Start Referral Form



### Eligibility Criteria:

Is Potential Client PREGNANT?  Maybe  Yes  No must be high need infant – please call to discuss

Lives in following zip codes: 78154, 78202, 78203, 78205, 78207, 78210, 78217, 78218, 78219, 78220, 78229, 78239, 78244

Referral Date: \_\_\_\_\_ Referring Agency: \_\_\_\_\_ Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Potential Client Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

\* If client is a minor, is parent/guardian aware of pregnancy?  Yes  No Language Preference:  English  Spanish

Race:  Black/African American  White  Biracial  Asian  Native Hawaiian/Pacific Islander  American Indian/Alaska Native

Ethnicity:  Hispanic or Latino  Non Hispanic and Non-Latino

Alternate Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

LMP (Last Menstrual Period): \_\_\_\_\_ EDD(Estimated Due Date): \_\_\_\_\_ Weeks Gestation: \_\_\_\_\_ Date Prenatal Care Began: \_\_\_\_\_

### Referral Indicators

- |  |   |
|--|---|
| <input type="checkbox"/> African-American*   | <input type="checkbox"/> No access to care/insurance                            |
| <input type="checkbox"/> Previous fetal demise (stillbirth/neonatal death)*          | <input type="checkbox"/> No prenatal care                                       |
| <input type="checkbox"/> Previous pre-term or low birth weight baby*                 | <input type="checkbox"/> Financial hardship                                     |
| <input type="checkbox"/> Drug/Alcohol Use*   | <input type="checkbox"/> Single parent  |
| <input type="checkbox"/> Depression or other mental health issues*                   | <input type="checkbox"/> Poor exercise/nutrition                                |
| <input type="checkbox"/> Abuse* _____  | <input type="checkbox"/> Excessively under or overweight                        |
| <input type="checkbox"/> Homeless*   | <input type="checkbox"/> Pregnancy less than 17 or greater than 35 years of age |
| <input type="checkbox"/> Gestational Diabetes/ Anemia                                | <input type="checkbox"/> Smoking  |
| <input type="checkbox"/> Maternal STD or HIV   | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Close interval pregnancies (2 pregnancies within 24 months) |   |

### -----Healthy Start Use Only-----

### Status of Referral:

- Pursued for Case Management –Assigned to Case Manager
- Pursued for Outreach Resources due to:  Ineligible  No High/Multiple Risk Factors – Assigned to Outreach Worker

Date assigned: \_\_\_\_\_

Case Manager/Outreach Worker: \_\_\_\_\_

Summary of initial client contact:

1<sup>st</sup> contact attempt date: \_\_\_\_\_  Face to Face  Telephone

\_\_\_\_\_

2<sup>nd</sup> contact attempt date: \_\_\_\_\_  Face to Face  Telephone

\_\_\_\_\_

3<sup>rd</sup> contact attempt date: \_\_\_\_\_  Face to Face  Telephone

\_\_\_\_\_

### Outreach Resources Provided

- |                                   |                                |
|-----------------------------------|--------------------------------|
| _____ Could not locate for R/R    | M. Transportation              |
| A. Counseling                     | N. Parenting Education Classes |
| B. Childbirth Preparation Classes | O. Breastfeeding Education     |
| C. Nutrition                      | P. Immunizations               |
| D. Resources for Immigrants       | Q. Well Child Checkups         |
| E. Housing                        | R. Baby Items                  |
| F. Dental Services                | S. Domestic Violence           |
| G. Adult Education Classes        | T. Family Planning             |
| H. Financial Assistance           | U. Prenatal Care Information   |
| I. Jobs/Job Training              | V. Infant Care Information     |
| J. Male Support Services          | W. Postpartum Care Information |
| K. Childcare Services             | X. Homeless Services           |
| L. Translation Services           | Y. Other: _____                |

Disposition Date: \_\_\_\_\_

Disposition Contact: \_\_\_\_\_

CM/Outreach Worker: \_\_\_\_\_

Phone

Fax

**Result of Pursued Referral:** ® Enrolled ® Ineligible ® No response/unable to locate ® Declined, reason: \_\_\_\_\_