BIH Eligibility Criteria
1) Self-identified African-American woman
2) At least 18 years of age at enrollment
3) No later than 26 weeks pregnant at enrollment

*Recruitment Date (Program Start Date): ____ / ____ / ____

PARTICIPANT INFORMATION (Add new participant)

Case Number: ____________________

*First Name: ____________________ Middle Name: ____________________ *Last Name: ____________________

Maiden Name: ____________________ *Participant’s DOB: ______ / ______ / ______

Home Address (Address 1): __________________________________________ Apt/Ste/Bldg # (Address 2): ___________

City: ___________________________ State: ___________ *ZIP Code: ________________

Mailing Address: ______________________________________________________

City: ___________________________ State: ___________ ZIP Code: ________________

Home Phone: ( ) ______-___________ Work Phone: ( ) ______-___________

Email: ____________________________

What is the best way to contact you? ____________________________________________

REFERRAL INFORMATION (Recruitment TouchPoint)

Date Referral Made (Provider): ____ / ____ / ____ *BIH Staff Name: ____________________________

*Due Date: ______ / ______ / ______

*First-time mom? ☐ Yes ☐ No ☐ Unknown

*Referral Source Type (Check primary source):
☐ Social Service Provider ☐ Word of Mouth
☐ Medical Provider ☐ Other BIH Participant
☐ County Health Department ☐ Returning BIH Participant (previous pregnancy)
☐ BIH Staff Outreach- Health fair ☐ Media
☐ BIH Staff Outreach- Street ☐ Other: ____________________________

For provider-based referrals, was the participant information received initially via automated list/report? ☐ Yes ☐ No

Name of Referral Organization (if provider-based referral): ____________________________

Contact Person: ___________________________ Phone Number: ( ) _____-_______

Name of Referring BIH Staff (if health fair or street outreach): ____________________________

Dismiss Participant from Recruitment Program (to be completed by BIH Staff)

*Program End Date: ____ / ____ / ____

*Dismissal Reason:
(CHECK ONE)
☐ Enrolled in BIH (consent signed)
☐ Needs could not be met by BIH
☐ Staff unable to contact ☐ Cannot participate due to transportation, childcare, or other barriers
☐ Not eligible ☐ Other: ____________________________
☐ No time available to participate
☐ Not interested

Fax Referrals To: Long Beach BIH Program
Fax: (562) 570-8187
Office PH: (562) 570-4323

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