



CONFIDENTIAL REFERRAL FORM
Perinatal Home Visitation Education Program



Eligible women must be expecting first baby.
Please refer as early in pregnancy as possible, must be before 28 weeks EGA

Date: _____ Email: _____

Person making referral: _____ Phone: _____

Provider/Agency/Facility: _____ Fax: _____

Name of client: _____ Date of birth: _____
Address: _____ LMP/EDD: _____
City: _____ ZIP: _____ Phone: _____
Was the client informed about of the referral? _____ Is the pregnancy confidential? _____
Ethnicity: _____ Spoken language: _____ Written language: _____
Planned hospital of delivery: _____

Issues of concerns: (known/suspected – check all that apply)

Table with 3 columns: HEARING IMPAIRED, SUSPECT DRUG/ALCOHOL USE, TOBACCO USE; BLIND/VISUALLY IMPAIRED, MENTAL HEALTH CONDITION, FOSTER CHILD; PHYSICAL DISABILITY, FAMILY VIOLENCE, TRANSITIONAL AGE YOUTH (TAY); JUVENILE JUSTICE INVOLVED, NO SUPPORT SYSTEM, HOMELESS; ADULT JUSTICE INVOLVED, DEPRESSION, UNSAFE LIVING CONDITIONS; EXPOSED TO TRAUMA, STRESSED FAMILY, TEEN PREGNANCY

Additional Comments:

Empty box for additional comments

For NFP Program use only

Final Disposition: Enrolled Not Enrolled Reason: _____

FAX THE REFERRAL FORM TO 562-570-4099
QUESTIONS? PLEASE CALL:
Lovvet Hollis, PHN at 562-570-4281 OR Eileen Margolis, PHN Supervisor at 562-570-4272
Lovvet.Hollis@longbeach.gov Eileen.Margolis@longbeach.gov
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