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)

☐ 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:

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
Lovvet.Hollis@longbeach.gov

OR

Eileen Margolis, PHN Supervisor at 562-570-4272
Eileen.Margolis@longbeach.gov

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