

# Healthy Start Referral Form



**Healthy Start**  
Having Healthy Babies

**Eligibility Criteria:**

- **PREGNANT \***
- **Live in zip code target area: 78154, 78210, 78219, 78202, 78220, 78203, 78239, 78205, 78217, 78244, 78207, 78218, 78229**

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

Agency Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Language Preference:  English  Spanish Ethnicity:  Hispanic or Latino  Non Hispanic or Latino

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

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

EDD(Estimated Due Date): \_\_\_\_\_ Trimester:  1<sup>st</sup> (1-12wks)  2<sup>nd</sup>(13-25wks)  3<sup>rd</sup> (26-40 wks)

**Referral Indicators**

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

**Healthy Start Use Only:**

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

\_\_\_\_\_

**Referrals Provided:**

- |                                   |                                |
|-----------------------------------|--------------------------------|
| A. Counseling                     | M. Transportation              |
| B. Childbirth Preparation Classes | N. Parenting Education Classes |
| C. Nutrition                      | O. Breastfeeding Education     |
| D. Resources for Immigrants       | P. Immunizations               |
| E. Housing                        | Q. Well Child Checkups         |
| F. Dental Services                | R. Baby Items                  |
| G. Adult Education Classes        | S. Domestic Violence           |
| H. Financial Assistance           | T. Family Planning             |
| I. Jobs/Job Training              | U. Prenatal Care Information   |
| J. Male Support Services          | V. Infant Care Information     |
| K. Childcare Services             | W. Postpartum Information      |
| L. Translation Services           | X. Homelessness                |
|                                   | Y. Other: _____                |

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

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

Care Coordinator: \_\_\_\_\_

Phone

Fax

**\*\*Result of Referral:**

Enrolled  Ineligible  No response/unable to locate  Resources & Referrals Only

Declined, reason: \_\_\_\_\_

