

Healthy Start Referral Form



Eligibility Criteria:

➤ **PREGNANT ***

Live in zip code target area: 78154, 78202, 78203, 78205, 78207, 78210, 78217, 78218, 78219, 78220, 78229, 28239, 78244

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 Prenatal Care Began: 1st (1-12wks) 2nd(13-25wks) 3rd (26-40 wks)

LMP (Last Menstrual Period): _____ If client is a minor, is parent/guardian aware of pregnancy? Y N

Referral Indicators

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

*Indicates High Risk Factor

Healthy Start Use Only:

Date assigned: _____

Case Manager/Outreach Worker: _____

Summary of initial client contact:

1st contact attempt date: _____ Face to Face Telephone

2nd contact attempt date: _____ Face to Face Telephone

3rd 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: _____

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