



Referral Form

Client Information

Referral Date _____ Client Name (First, MI, Last) _____ DOB _____

Phone Number (____) _____ Medicaid Number _____ Preferred Language _____

Address _____ City _____ State _____ Zip _____

Race Black/African American White Other _____ Hispanic YES NO

Type of Referral

____ Prenatal Referral

Due Date _____

First Time Mom YES NO

____ Infant Referral

Infant Gender F M

Parent/Care givers name _____

Parent/Care givers DOB _____

Relationship to infant _____

Reason for Referral

Mother

- < 18 years old
- Substance Abuse
- Second Trimester or no Prenatal Care
- Chronic Condition
- Pregnancy interval < 18 months
- Had a baby born 3 weeks or more before due date
- Had a baby weighing less than 5 lbs. 8 oz
- Had a baby not born alive

Infant

- Low birth weight (less than 2000 grams/ 4lbs. 7oz)
- Admitted to NICU
- Positive for substance

Other Factors

- Open Investigation with DCF
- Child not in mother's guardianship
- Other _____

____ ICC Referral (*Interconceptional care is for clients who are not pregnant and have experienced a fetal/infant loss, have had an infant removed from the home, or have placed an infant up for adoption*)

Client's youngest child's age _____

Fetal/ Infant Loss Infant Removed from Home Mother has made a life plan for the infant

Additional Comments:

Referring From/ Title _____

Referring Agency _____ Phone _____