## **Family CORE**

## <u>C</u>oordinated $\underline{0}$ -5 years <u>R</u>eferral <u>E</u>xchange Referral form for prenatal, infant and young children home visitation programs

## Please fax this form to **503-472-9731**.

The person or family being referred will be contacted.

We will provide a follow-up letter to you regarding the outcome of the referral.

For questions or mailed submissions please call Public Health 503-434-7525

412 NE Ford Street, McMinnville, OR 97128

Date	e:			
Per	son being referred:			
<u></u>			Date of Birth:	
	ent or Guardian names (if a child): Relationship:		Date of Birth:	
	Relationship: Relationship:			
			<del></del>	
Pho	one number			
Hon	ne address		<del></del>	
Prin	nary Language			
Doe	es the family know about this referral O YES	6	O NO	
Plea	ase check all that apply			
0	Medical condition	0	Newly pregnant needing assistance	
	Please specify	0	Limited income/resources (i.e. lack of	
0	Teen parent		transportation, food, housing)	
0	Parent with developmental delays		Lack of adequate parenting skills	
0	Child with or at risk for developmental delays		Domestic violence (present or history of)	
0	Infant feeding/weight gain problems		Lack of client/patient follow through	
0	Risk of maternal depression	0	Substance abuse-please describe below	
0	Isolation/lack of support	0	Tobacco Use	
0	Challenging child behaviors	0	Other- please describe below	
Add	litional Information:			
	Referring Source Information:			
Person (provider) to receive referral follow-up information:				
Person/Organization completing referral form: Fax Number: Fax Number:				
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A Family Place Relief Nursery Babies First Cacoon Early Head Start/Head Start

Early Intervention/Early Childhood Special Education Healthy Families ~ Healthy Start Maternity Case Management Mothers and Babies