Healthy Baby/Healthy Child Clinical Referral Form | October 2017

Phone: 617-534-5832 FAX 617-534-5355

Client Basic Information

Referral Date: ___________________(mm/dd/yyyy) Client ID: _________________________

What is your name? (first) __________________________ (last) _________________________________

What is your date of birth? _______________(mm/dd/yyyy) ❑ Declined to answer

Demographics

What is your address? (street) ____ (apt #)______ (floor)____ (box) _____

(city)____ (state)________ (zip)____________ (PO box #)___________

What is your mailing address? ❑ Same as above

(street) _____________________________________ (apt #)______ (floor)____ (box) _____

(city)____ (state)________ (zip)____________ (PO box #)___________

What is your primary phone number? ( )________ ❑ Home ❑ Cell ❑ Work ❑ Do not have phone
❑ Other, please specify: _________________

What is your secondary phone number? ( )________ ❑ Home ❑ Cell ❑ Work ❑ Friend/family
❑ Other, please specify: _________________

What is your emergency contact information? Name ______________________ Phone number ( )________

What is your email address? ____

What is the best way to contact you? ❑ Home phone ❑ Cell phone ❑ Text ❑ Email

Are you of Hispanic, Latino, or Spanish origin? Select all that apply.
❑ No, not of Hispanic, Latino, or Spanish origin
❑ Yes, Mexican, Mexican Am., Chicano
❑ Yes, Puerto Rican
❑ Yes, Cuban
❑ Yes, another Hispanic, Latino, or Spanish origin — Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on. ____________________________________
❑ Don't know
❑ Declined to answer

What is your race? Select all that apply.

❑ American Indian or Alaska Native	❑ Asian Indian	❑ Black or African American
❑ Chinese	❑ Filipino	❑ Guamanian or Chamorro
❑ Japanese	❑ Korean	❑ Native Hawaiian
❑ Samoan	❑ Vietnamese	❑ White
❑ Other Asian	❑ Other Pacific Islander	

❑ Other (please specify): ___________________________________
❑ Don't know ❑ Declined to answer

What is your Ethnicity? List all that apply. ____

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What is your primary or preferred language? ____

Do you need an interpreter? ❑ Yes ❑ No

Referral Information

What is the referral type: ❑ Prenatal ❑ Postpartum ❑ SIDS/FIMR ❑ Infant ❑ Child ❑ FFI

(If Prenatal) What trimester are you currently in? How many weeks pregnant are you?
❑ 1st (1-12 weeks) ❑ 2nd (13-26 weeks) ❑ 3rd (27-42 weeks)

Program referral select all that apply: ❑ HBHC ❑ Welcome Family ❑ HSiH ❑ VIAP

How did you hear about this program? Select all that apply.

❑ Provider (OB/GYN, primary care physician, RN)
❑ Outreach worker
❑ Flyer / Brochure / Poster / Billboard
❑ Internet / social media
❑ BHSI Site
❑ Program staff
❑ Family/friend
❑ Health or resource fair
❑ Previous client
❑ Other (please specify): ________________________

Who referred you to this program?

❑ Provider (OB/GYN, primary care physician, RN)
❑ Outreach worker
❑ Previous client
❑ Other (please specify): _________________________________
❑ Program staff
❑ Family/friend
❑ I referred myself (self-referral)

(If not a self-referral) Is the client aware of referral? ❑ Yes ❑ No

Contact person name: ____ Title: ________________________________

What is the name of the referral site? _____________________________ Phone # (   )________

What is the reason for referral? Select all that apply. (Options continue on Page 3)

Mother/ Father/ Guardian (clinical)

❑ Advanced maternal age >35 yrs
❑ Alloimmunization
❑ Asthma (on daily medication)
❑ Autoimmune conditions, specify: _________________
❑ Blood disorder, specify: ______________
❑Cancer, specify: ________________________________
❑ Cardiac condition, specify: ______________
❑ Cervical Insufficiency, specify: ___________________
❑ Currently misusing substances
❑ Diabetes, specify: ______________
❑ Enter prenatal care in the 3rd trimester
❑ Fetal malformation, specify: ______________________
❑ Hepato-renal disease, specify: ___________________ (gallbladder, fatty liver, hepatitis, pancreatic disease)
❑ Hyperemesis
❑ Hypertension
❑ Infectious disease, specify: ___________________
❑ Isoimmune or idiopathic thromocytopenia
❑ Mental Health disorder: (depression, bipolar, schizophrenia, severe anxiety, maternal depression)
Please specify: _________________________________
❑ Multiple gestation (twins, triplets, or beyond)
❑ Obesity (>30 bmi) ❑Underweight (<19 bmi)
❑ Placenta abnormality, specify: _________________
❑ Preterm labor
❑ Previous poor birth outcome, specify: ___________
❑ Previous preterm birth
❑ Second trimester pregnancy loss
❑Sickle cell disease
❑ Third trimester bleeding
❑Thyroid disease, specify: _______________
❑ Other, specify: ________________________

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Mother/ Father/ Guardian (social)

- ❑ Child support
- ❑ Employment
- ❑ Housing (unstable, doubled up, shelter/motel, etc.)
- ❑ Nutrition/ food security
- ❑ Stress, specify: _______________
- ❑ Violence/abuse/neglect
- ❑ Custodial support
- ❑ Experienced loss of a partner/child
- ❑ Lack of social network
- ❑ Parenting
- ❑ Teenager
- ❑ Other, specify: _________________

Infant/child

- ❑ Developmental delays
- ❑ Hospitalization for medical condition
- ❑ Low birthweight
- ❑ Prematurity
- ❑ Significant medical condition/chronic illness
- ❑ Violence/abuse/neglect
- ❑ Environmental concerns
- ❑ Injury at home (other than abuse)
- ❑ Nutrition
- ❑ Risk for developmental delays
- ❑ Under immunized
- ❑ Other, specify: ____________________

Child Information

Child 1

What is your child's name? (first) ________________________________ (last) _________________________________

What is your child's date of birth? ______________(mm/dd/yyyy)

What is your child's sex? ❑ Female ❑ Male

Delivery type: ❑ C-section ❑ Vaginal

What was your child's gestational age? _________

What was your child's birth weight? ____________ (specify in pounds/ ounces)

Child 2

What is your child's name? (first) ________________________________ (last) _________________________________

What is your child's date of birth? ______________(mm/dd/yyyy)

What is your child's sex? ❑ Female ❑ Male

Delivery type: ❑ C-section ❑ Vaginal

What was your child's gestational age? _________

What was your child's birth weight? ____________ (specify in pounds/ ounces)

Client Information

What is your expected date of delivery? ______________(mm/dd/yyyy)

Gravida: _________ Para: _________________

What is your Pediatric care site? _________________________________Provider: _____________________________

What is your Prenatal care site? _________________________________ Provider: _____________________________

What is your delivery hospital? __________________________________ Provider: _____________________________

Is this a HSIH referral? ❑ Yes ❑ No

When is the best time for a home visit? Select all that apply. ❑ Morning ❑ Afternoon ❑ After 5pm ❑ Saturday

Referral Notes:

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