Healthy Families America® — AFFILIATE —

Public Health Solutions

THIS FORM IS TO BE COMPLETED BY REFERRAL AGENCY STAFF ONLY

Mother's Name: ______________________ DOB: ______________

Father's Name: ______________________ DOB: ______________

Phone: ______________________ Can a message be left? Y/N

Address: ______________________ City: ______________ Zip: __________

Baby's Name: ______________________ Due Date or Date of Birth: ______________

Hospital/Clinic: ______________________ Physician: ______________________

Insurance: ☐ **Private** ☐ **Medicaid** ☐ **No Insurance** ☐ **Under Insured** ☐ **Other**

Primary Risk Factors: *Please check all that apply*

- ☐ **Parent is a teen** (Age 19 or younger)
- ☐ **Parent is not married**
- ☐ **First- time parent**
- ☐ **WIC/Medicaid/SNAP Eligible** (Low-income)
- ☐ **Education under 12 years (not HS grad/No GED)**
- ☐ **Limited family/social support**
- ☐ **History of/current Substance use**
- ☐ **History of/current depression or psychiatric care**
- ☐ **Unstable housing** (homeless, frequent moves, etc.)
- ☐ **Parent with cognitive or physical challenges**
- ☐ **History of/current CPS involvement**
- ☐ **Baby with extended NICU stay**
- ☐ **Baby born premature or low birth weight**
- ☐ **Adoption or abortion sought for pregnancy**
- ☐ **Late/none/poor prenatal care**
- ☐ **Baby born with medical needs/disabilities**
- ☐ **Marital problems or limited partner support**
- ☐ **Parents report moderate/extreme stress**
- ☐ **History of Sexual Abuse**
- ☐ **Unemployed** (parent or partner)

Notes: ____

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Screen Completed By: ______________________ **Date:** ______________

Agency: ______________________ **Contact Number:** ______________________

FAX ALL REFERRALS TO PUBLIC HEALTH SOLUTIONS- 402-223-0075
For questions reach out to Program Manager Angela Johnson:
ajohnson@phsneb.org or 402-826-6696

☐ **Refused Referral**

FAXED
Date: __________
Initals: __________